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CATASTROPHIC HEALTH CARE COVERAGE: MENDING A BROKEN PROMISE

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

FEBRUARY 19, 1986

Printed for the use of the Committee on Aging

Comm. Pub. No. 99-565

U.S. GOVERNMENT PRINTING OFFICE
60-127 O WASHINGTON : 1986

For sale by the Superintendent of Documents, Congressional Sales Office
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H141-38

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CATASTROPHIC HEALTH CARE COVERAGE: MENDING A BROKEN PROMISE

WEDNESDAY, FEBRUARY 19, 1986

House of Representatives,
Select Committee on Aging,
Subcommittee on Health and Long-Term Care,
Washington, DC.

The subcommittee met, pursuant to notice, at 9 a.m. in room 311, Cannon House Office Building, Hon. Claude Pepper (chairman of the subcommittee) presiding.

Members present: Representatives Pepper, Oakar, Synar, Vento, Wyden, Erdreich, Ridge, McCain, Meyers, and Kolbe.

Staff present: Kathleen Gardner Cravedi, staff director; Melanie Modlin, assistant staff director; Peter Reinecke, research director; Patricia Butch, congressional fellow; Lanny Miller and Hal Wallach, detailees; Dr. Leonard Scherlis, consultant to the subcommittee; Mark Hickman, intern; Lillian Simmons, volunteer; Mark Benedict, minority staff director; Lori Lightfoot, minority assistant staff director; Patrick McCarthy, detailee; and George Culver, intern.

OPENING STATEMENT OF CHAIRMAN CLAUDE PEPPER

Mr. Pepper. The committee will come to order, please.

We have a distinct honor and great pleasure this morning in having with us to make his first appearance before a congressional committee the distinguished new Secretary of Health and Human Services, Dr. Otis R. Bowen.

Dr. Bowen, we are mighty proud to have you here. It is a great honor that you have come here to testify before our subcommittee in your first appearance on Capitol Hill.

We think the subject of your appearance here today is one of critical importance for both Congress and the country. Therefore, we all the more appreciate the significance of your appearance.

In the preamble for the historic piece of legislation creating Medicare in 1965, it was declared that access to good health care was the right of all Americans and that there should be no discrimination with respect to access to the finest health care America has to offer based on a person's ability to pay for such care.

In the 20 years since Medicare has been enacted the United States has seen a dramatic increase in the cost of health care. While the cost of health care has risen about 50 percent for the general population in the past 10 years, it has increased 100 percent for seniors.

Medicare was created in 1965 because elderly people were then spending about 20 percent of their income on health care. Today even with the great benefits that Medicare provides for the elderly people, that figure is just about the same. The elderly pay about 20 percent of their income for their health care.

It is extremely difficult for the elderly to find a doctor who will accept what Medicare offers as full payment. The number of doctors accepting the Government's decision—and they ought to be willing to trust their Government, it seems to me, to be fair to them as well as to the patient. I am proud to say that the number accepting the Government's decision as to what is a fair fee to be charged for their services has increased. We hope it shall rapidly increase further.

There are great gaps at the present time in Medicare coverage, which we all know. It does not cover eyeglasses, dental care, hearing aids, foot care, routine persistent visits, organ transplants, most nursing home or in-home care for the chronically ill elderly.

Nor does it provide preventive care. A member of my family told me last week that he and his wife are covered by a health plan, a health program—something in the nature of an HMO. They got a telephone call from this organization saying it has been some time since the husband has had a checkup; wouldn't it be wise for him to come in and get a checkup.

The reason they called was they thought they might find something in the checkup that would prevent him from having a serious illness at a later time which would be expensive for them.

Medicare pays for about 45 percent of the average costs for elderly health care bills. While Medicare does an adequate job of assisting seniors to pay for costs associated with illness requiring hospitalization, virtually no coverage is available under the Medicare Program or most private insurance programs, for that matter, to help senior citizens when a chronic catastrophic illness strikes.

One of my brothers before passing away not long ago was in the hospital for 6 weeks for a checkup. He got a bill for $26,000. He was worth probably about $40,000 altogether. He had to be in the hospital a while. Fortunately he was covered by Medicare. Otherwise he would have been wiped out of whatever assets he had.

We know also that Alzheimer's disease and many other types of illness, for example, are not covered by Medicare.

Today 20 million Americans suffer from chronic heart conditions and roughly one-third of those so afflicted are elderly.

Today over 10 million Americans suffer from chronic lung disease. Fully one-quarter of these are elderly.

Today 5 million Americans suffer from the horrors of cancer. The elderly comprise nearly one-third of those who are victims of cancer in our country every year.

Today up to 4 million Americans have Alzheimer's disease. Over 90 percent of those claimed by this cruel and torturous affliction are elderly.

This year over 500,000 Americans will suffer debilitating strokes. At the insistence of the subcommittee and committee, the members who are here today, we made possible a wider use of the checkup of high blood pressure, and that has reduced, we are informed happily, the number of strokes that people have sustained as a result of high blood pressure because high blood pressure is rather easily and rather cheaply treated.

This year as many as 1 million Americans will be forced into poverty and onto the welfare rolls due to the catastrophic costs of the health care they need.

It is partly out of frustration and partly out of fear that senior citizens have increasingly turned to the purchase of supplemental health insurance. About 90 percent of all elderly own such policies, for which they pay dearly.

This subcommittee is proud to recall we had some effect in respect to current Medicare insurance. The subcommittee continues to hear sad stories of abuse, however, in the sale of Medicare insurance to seniors at the hands of high-pressure salesmen alert to the fears of older people about their health care.

An 83-year-old Minnesota woman had purchased a total of 28 insurance policies in the last 5 years of her life, for which she paid out more than $15,000 to keep her insurance coverage current and ready to use when she needed it.

Tragically, the time came when this elderly woman looked to her insurance to pay for her care in a nursing home where she spent the last 18 months of her life. Not one of the 28 policies covered her nursing home stay, and she died practically penniless.

An elderly woman from Maine had purchased a policy through a senior citizen organization several years ago in order to get nursing home coverage. Last year she entered a nursing home. Her husband thought her policy should pick up the costs, but he soon learned that it only covered Medicare-approved skilled care; it did not cover the intermediate care that she required.

The husband ended up paying over $2,000 a month until his wife died 6 months later. He said, "I would have spent everything I had for my wife."

An insurance broker in Massachusetts, who will testify before the subcommittee today, will detail how he preyed on the fears seniors have regarding their health care costs and eventually served 1 year in jail after he was found guilty of selling dozens of elderly persons more insurance than would help them or than they could possibly afford.

Medicare and the various supplemental plans provide excellent coverage against acute illnesses such as heart attack or stroke, from which there is a reasonable expectation of recovery. Even post-hospital care in nursing homes is provided at a minimal cost.

However, once the person becomes so desperately ill that there is no hope of making him self-sufficient, Medicare and all other supplemental plans come to an end, and the patient and his or her family are left to fend for themselves.

The other options left to such sadly situated Americans can be equally frightening. One is advised to wait until all liquid resources are depleted to the level of $3,000 for a couple and $2,500 for an individual.

I well remember hearing we had a lady who was here from New York to testify about her mother's illness with Alzheimer's disease. She said in 3 months her sister and she were totally deplete. All of the assets they had were spent in taking care of their mother with Alzheimer's disease.

Now, today, as I said, we have the Honorable Secretary with us, but I first, Mr. Secretary, want to hear from the members of my subcommittee who want to make quick statements in the record.

Mr. Wyden.

STATEMENT OF REPRESENTATIVE RON WYDEN

Mr. **Wyden**. Thank you very much, Mr. Chairman. I want to be brief and I know other members have comments, and I just want to make a couple very quick points, Mr. Chairman.

First, I commend you for your leadership in looking at this subject. It is one of great importance. Mr. Chairman, it is my view that it is really a disgrace that our great Nation seems to be the only western industrialized nation without any catastrophic health coverage.

I think it is very timely that we take this up. I must say, Mr. Chairman, I am interested that the administration wants to pursue it because I think there is something of a contradiction in the administration's health care priorities.

The budget that the President sent up to Capitol Hill savages the Medicare and Medicaid Program. It has 54 billion dollars' worth of cuts in Medicare over 5 years and more than $15 billion in Medicaid, and at the same time the administration suggests that we pursue catastrophic coverage.

So, I am glad that they are interested, but I think there is something of a contradiction in their health priorities.

The last point I would like to make, Mr. Chairman, is I have had a chance to read what Dr. Bowen, has written about catastrophic coverage in the past. I think that his plan is going to take a lot of work, at least based upon what we have seen.

I know Dr. Bowen has said he wants to put a lot of work into it. The reason I say that, Dr. Bowen, is I do not think that, as it stands now, it would help one of the people who is going to be here before the subcommittee today. They have not spent enough days in the hospital.

So, I am glad that you are willing to work with the subcommittee, and based upon what I have read, I think it is going to take a lot of work. You will find the subcommittee members on both sides of the aisle want to pursue it.

Thank you, Mr. Chairman.

Mr. **Pepper**. Thank you, Mr. Wyden.

Mr. McCain.

STATEMENT OF REPRESENTATIVE JOHN McCAIN

Mr. **McCain**. Thank you. Thank you for coming to testify before the subcommittee, and thank you, Mr. Chairman, as always for conducting this hearing.

You always have a unique ability to address those issues which are most important to our elderly citizens in America.

Mr. Secretary, I come from a State that has a very large elderly and aging population which is dramatically increasing. The high cost of health care is an issue of deep concern to all of them. What most concerns me about senior citizens today is that we are at a point where they are not as concerned about dying as they are concerned about experiencing a catastrophic illness which will then impoverish them and reduce them to conditions of poverty for the years remaining.

I think this issue is long overdue to be addressed, and I believe that various proposals, including the plan developed by the Advisory Council on Social Security in 1984, are an excellent starting point.

I will be interested in your testimony as to why you feel it will take an additional year for us to develop a plan, because I think this, like a number of other issues, has been very deeply studied and investigated already.

I also look forward to developing a program which will have great involvement in the private sector. I do not believe that we can come up with a workable plan that will, like so many of its predecessors, preclude coming back and back and back for additional infusions of taxpayers' dollars unless we have a deep commitment and involvement on the part of the private sector. We must provide a great deal of flexibility and opportunity.

I look forward to your testimony today, and, Mr. Chairman, I ask unanimous consent that Mr. Regula's opening statement be included in the record.

Mr. PEPPER. It will be without objection.

[The prepared statement of Representative Ralph Regula follows:]

PREPARED STATEMENT OF REPRESENTATIVE RALPH REGULA

Honorable Chairman and Members of the subcommittee, I am heartened by the growing concern for the problem of catastrophic and long-term care as evidenced by the President in his State of the Union message and the Chairman's decision to convene this hearing for the same purpose.

The distinguished Secretary of the Department of Health and Human Services, Dr. Otis Bowen, leads our list of witnesses. It is appropriate that his first appearance on Capitol hill should be to tesify on this important matter.

Unlike many problems, few Americans realize that Medicare and most private insurance supplements fail to cover catastrophic illnesses. Medicare was established to ease the financial burden of health care to our nation's aged. But it only pays for a portion of those costs. Unfortunately, what Medicare does and does not cover has been a source of confusion for our elderly since the program's inception.

In the 1970s, insurance policies came into being claiming to cover the "gaps" in Medicare coverage. In the absence of regulation, fraud and misrepresentation by unethical agents resulted in dollars being spent for redundant coverage. Our subcommittee found that many agents were selling the elderly three, four, five and sometimes as many as thirty different policies for the same coverage.

Congress responded by enacting legislation that provided guidelines to the States in regulating Medicare supplemental policies based upon model regulations developed by the National Association of Insurance Commissioners, the association of state officials who regulate insurance. Through these efforts the elderly became aware of the "gaps" within their health coverage and what legitimate insurance policies were available to meet their needs.

Throughout this period the issue of catastrophic and long-term care has been present. Much has been said about the need for such coverage. In his comments, the Chairman adequately illustrates the danger of prolonged illness to all persons. According to his estimates, a New York family, with savings of $200,000 would be financially exhausted within 48-60 months based on the average cost of most catastrophic illnesses.

Clearly, momentum is building to address the problem. Various proposals are being offered ranging from an enlargement of Medicare coverage to private sector mechanisms. Although the Administration has taken no official position Dr. Bowen has set forth a measure, developed by the Advisory Council on Social Security, which would strengthen Medicare Part A and B to cover these expenses. Also, certain Members of Congress has offered a bill to replace Medicare with a health care IRA that would include catastrophic and long-term care. And finally, the distinguished Chairman, and I, have been working on separate initiatives to meet the aged's needs. Based on years of studying this issue, I am convinced that the answer to the problem lies predominantly in the private sector. I intend to offer legislation following the conclusion of this hearing.

I commend the Secretary on his efforts in this area. They have been a catalyst to Congress in stimulating action and providing us with a framework in which further discussion will be conducted. I am encouraged by the Secretary's interest in this area and I welcome him to join me, and other Members, who are attempting to address this dilemma in finding a prompt and appropriate answer.

Mr. **Pepper**. Mr. Erdreich.

STATEMENT OF REPRESENTATIVE BEN ERDREICH

Mr. **Erdreich**. Thank you, Mr. Chairman. I also want to thank Dr. Bowen for testifying before us.

This is an area we all have deep interest and concern about. I would urge one thing, Dr. Bowen, as you look at it and pursue your study, whatever is done, let us go forward in cleaning up some of the overlaid paperwork, confusing letters on claims, and difficulty for the average citizen to deal with Medicare in 1986.

I hope what we do can improve the system to make it more understandable and also at the same time to get at some of the problems of folks preying on seniors with assertions that they have a lack of full coverage or full amount of coverage they may need with a clearer and simpler system under Medicare itself. I would urge that HHS pursue that as quickly as possible.

Thank you.

Mr. **Pepper**. Thank you.

Mr. Ridge.

STATEMENT OF REPRESENTATIVE THOMAS J. RIDGE

Mr. **Ridge**. Thank you, Mr. Chairman.

I, too, was very pleased and heartened by the President's recognition in his State of the Union Address of the need to address the issue of catastrophic health care coverage.

I would say, Mr. Chairman, that I am most hopeful that with the President's initiative as well as with your continuing leadership, support, and knowledge we can address this most human and humane concern of all our senior citizens, be they presently ill and suffering the tremendous economic consequences of long-term illness or be they presently healthy and worrying about it.

I am convinced that based on observing your and the President's initiative and working together on the Social Security Compromise in 1983 that when that train leaves the station, you and the President are at the throttle and a lot of other people on board, and this can be called to the attention of the entire country.

Thank you.

Mr. **Pepper**. Miss Oakar.

STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Ms. **Oakar**. Mr. Chairman, first of all I want to commend you for your leadership here. You are one of the champions for the elderly. When I came here 9 years ago, you were introducing reforms for

Medicare, and unfortunately we have not adopted them. I think we are long overdue to reform Medicare.

Dr. Bowen, we are of course delighted to have you. I was disappointed when my friend Peggy Heckler never could appear before our committee. So, I think it is great you are here today.

I want to say this, though: I am very, very concerned about robbing Peter to pay Paul. Let me tell you what I perceive is the problem. What we really need is to have somebody talk about what is really necessary in Medicare, which is not a new idea; that is, we ought to be offering comprehensive coverage, period.

Now, to do it piecemeal is interesting—and there is certainly a need for catastrophic coverage, although, as you know, the average senior spends 6 days in the hospital. But for those few that will need catastrophic coverage, we ought to provide that.

On the other hand, I get very concerned when I see that Medicare covers only 40 percent of a person's need. But when I see the administration proposing to charge copayments as a disincentive for home health care, proposing to delay eligibility, proposing to freeze lab payments and the increase in the initial cost that seniors pay, which as I understand is a struggle you are having with OMB—they want you to charge more out-of-pocket expenses for catastrophic coverage and you want to do it another way—I am very, very concerned about that because I think we are talking about something that is really important.

No one wants to pay attention to the $57 billion in cuts that my friend Mr. Wyden referred to earlier. It is a subtle form of hypocrisy, I think, to talk about how we want to reform one little part of the Medicare Program and then take away all these other things.

So, I would prefer that you go back, Doctor, and look at some of the recommendations of your own commission in 1982.

One of the areas that I want to commend you about that you recommended was the need for further research in the area of prevention and the need for further research and further demonstration projects to show that if we offer comprehensive coverage we can avoid catastrophic problems.

I have to say that I do not buy the idea of coming in piecemeal about the Medicare thing. I think we have to look at it comprehensively, look at the area of prevention, look at the area of ambulatory care, and look at the area of catastrophic problems but not clobber the people who need preventive care and ambulatory care and then talk about the people who need catastrophic care.

I mean, people need comprehensive coverage, and we ought not to be robbing one area to supplement another. So, let's look at this comprehensively. That is what your commission did in 1982. I am hoping that you will lend that dimension because you are by profession a health care provider. You know what those problems are, I assume.

So, I am very concerned about the administration's cuts. I am afraid that if we come up with this plan, you are just going to cut all the real barebone necessities even further. It is just not the right thing to do.

We ought to be offering every senior, every American comprehensive health coverage, period. Then we will not have this competition.

Thank you, Mr. Chairman.

[The prepared statement of Representative Oakar follows:]

PREPARED STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Thank you, Mr. Chairman, for convening this hearing on the administration's proposal to develop catastrophic coverage under Medicare. I want to commend you and your staff once again for your continuing, excellent efforts to help senior citizens and improve their health care programs.

I am so pleased that the Secretary of Health and Human Services, Dr. Otis Bowen, has agreed to join us today and tell us more about the administration's plans for Medicare. As a past practitioner in the fields of both medicine and politics, Dr. Bowen is certainly well aware of the importance and difficulty of his task, and eminently qualified to undertake it. I appreciate the beginnings of our dialogue today, and hope he will continue to consult openly with the knowledgeable members of this committee in developing his proposals for Medicare.

The outlines of the administration's new catastrophic benefit for Medicare are still hazy, but the need for Medicare reform is clear. Today, Medicare covers less than half of the elderly's health care expenses. Hospitalization coverage is limited to 90 days. Coverage for physician services is capped at 80 percent of "reasonable" charges; although Medicare's share of actual physician charges is usually much less. Medicare pays nothing for preventive care, prescription drugs, hearing aids, eyeglasses, or dental care. It pays next to nothing toward long-term care. As comprehensive health care plans go, Medicare simply does not measure up. It does not adequately serve the elderly's health care needs.

So far, however, the administration's proposals for Medicare have been oriented more toward budget cuts than toward real reform. The President's fiscal 1987 budget calls for $55 billion in Medicare cuts over the next five years, including significant increases in out-of-pocket charges to the elderly. This budget is just another in a long string of administration proposals to slash Medicare spending. In fact, the President's 1982 Advisory Commission on Social Security, which was chaired by Dr. Bowen, called for huge increases in Medicare premiums and copayments, delayed eligibility for Medicare, and benefit restrictions which would have hurt many elderly and disabled beneficiaries. I hope the Secretary's new catastrophic coverage proposal will signal a departure from these unfair cuts and a new movement toward constructive reform.

This kind of reform is, indeed, possible. In this Congress, I have introduced a package of Medicare reform legislation which would fill in the gaps in Medicare coverage in ways that are cost-effective. The first of my bills, H.R. 1401, is based on pilot long-term care programs which currently are operating with grants from the Robert Wood Johnson Foundation. These programs offer coordinated, comprehensive long-term-care services, substituting home- and community-based care for institutional care whenever possible. Already, these programs are showing initial findings of cost savings. And, they are helping many elderly to remain in their own homes.

Another bill I have introduced, H.R. 1402, would offer a new preventive care benefit under Medicare. My legislation would establish a Federal version of "Medifill" insurance, which many seniors now purchase to help pay for health charges not covered by Medicare. However, because the Federal Government could offer "Medifill" policies at substantially lower administrative costs, we could provide more coverage for the same price. Under H.R. 1402, seniors could purchase a Federal "Medifill" policy which would also cover an annual physicial checkup, including screening for cancer and other health conditions.

I hope the Secretary will have a chance to review my legislation and that offered by Senator Pepper today. I know I will look forward to the development of new Medicare proposals to provide more comprehensive health care coverage for our elderly without increasing the burdens on their already-strained budgets.

Mr. PEPPER. Mr. Swindall.

STATEMENT OF REPRESENTATIVE PATRICK L. SWINDALL

Mr. SWINDALL. Thank you, Mr. Chairman.

I first of all, too, want to commend you for the timeliness of this hearing.

I was privileged here in the last recess to talk and listen to a number of my senior citizens. I found that without a doubt the quality of life issue remains a very paramount issue, and certainly catastrophic health coverage is one of those issues.

I found that they were very encouraged about the President's initiative in this area. I must confess that I hope that this hearing and the hearings that follow will be a bipartisan effort to focus on the problem and not simply a platform for partisanship and administration-backing, because clearly this is a problem that I think transcends partisanship, transcends this administration or any other administration.

I would also like to focus very briefly on another aspect of catastrophic insurance, one that had not really occurred to me fully until I was reading my mail this morning. I received a letter from a young couple from Conyers, GA, part of my district.

Essentially, it was a lengthy letter that set forth a problem that she had with a child who is now 5 years old who has a congenital respiratory problem. She pointed out the fact that they, in the next year, will use up their entire 500,000 dollars' worth of coverage.

The point she made was very, very relevant to what we are going to be looking at here. She said it seems that a Government that can commit money for research and development to save a child like this from premature death can also focus on the next aspect, and that is to allow a family that makes that commitment the opportunity to support such a child without literally stripping the family of their financial resources and certainly their emotional need.

I would hope as we look at this we see it as far more than a senior citizen problem but also a problem that affects individuals who do have children who are saved from a premature death. As a pro-life individual I think that it is even more incumbent on us in the pro-life community to recognize that with the commitment to life comes a commitment that goes far beyond simply saving individuals from the disasters of misfortune but also to maintain the quality of life thereafter.

Thank you, Mr. Chairman.

Mr. PEPPER. Mr. Synar.

STATEMENT OF REPRESENTATIVE MIKE SYNAR

Mr. SYNAR. Thank you very much, Mr. Chairman.

I think the facts are very clear. By the year 2000, 13 percent of the population will be over the age of 65. By the year 2040, the baby-boomers will be in full bloom, and there will be at least 5 million Americans in need of nursing homes.

The average cost of a nursing home in this country is $20,000 to $30,000, which means only the wealthy or the destitute can afford nursing homes.

That impact will probably be as great on rural America as any other place because of the lack of nursing homes there and the lack of skilled nurses.

You know, Medicare can offer us a viable option with home health care. It does not.

Therefore, today's hearing on catastrophic illnesses, how we deal with them, is only a start of what has to be a comprehensive look at all health care in this country. I am hopeful that today's hearing will trigger that comprehensive look.

[The prepared statement of Mr. Synar follows:]

Prepared Statement of Representative Mike Synar

Mr. Chairman, I want to thank you for holding hearings on catastrophic health insurance. We as members of the Aging Committee know very well that the rising cost of health care and the gaps in Medicare coverage are the major concerns of senior citizens today.

I am interested in the concept of catastrophic health insurance and appreciate the opportunity today's hearings will provide to learn more about this proposal. I hope the Aging Committee, insurance companies, health care providers and senior citizens can work together to solve not only the problem of paying for medical bills after a lengthy illness, but also provide long term care coverage.

Meeting the long term health care needs of our growing elderly population is a problem that the Congress must begin to address. It is particularly a problem in rural areas because there are fewer nursing homes and skilled nurses. By the year 2000, 13% of the population will be age 65 and older. It's estimated that as many as 5 million elderly Americans will need nursing homes by the year 2040, when the peak of the baby boom generation reaches old age.

Right now, families provide most of the long term care in this country. As the baby boom population grows older and mortality rates continue to decline, it will become more difficult for families to fulfill this function. Caring for a family member at home can be expensive as well as physically and emotionally draining.

Home health care provides the most cost-effective way to care for elderly on a long-term basis. Regrettably, the nation's home health care system is not a viable option for most senior citizens since medicare will only pay for skilled nursing care when the individual is literally homebound and unable to leave the house on a short term bases.

For many senior citizens, the only option left is a nursing home. Ironically, only senior citizens which are considerably wealthy or destitute can stay in a nursing home. On average, a nursing home costs $20,000 to $30,000 per year. Medicare pays only for health care costs associated with severe, short term illnesses and will pay for nursing home stays only in very rare circumstances. Medicaid does extend coverage to nuring home stays, but is limited only to low-income senior citizens. It's a tragedy that seniors have little choice but to spend all of their life savings and liquidate their assets leaving them so poor they can qualify for Medicaid.

We must begin now to address this problem. It is a time bomb which is quickly ticking toward explosion.

Mr. **Pepper**. Thank you, Mr. Synar.

Ms. Meyers.

STATEMENT OF REPRESENTATIVE JAN MEYERS

Ms. **Meyers**. Thank you, Mr. Chairman.

The problem of the consistently long-term ill elderly is a problem not just for that elderly person but for the whole family.

In the past we know that people have had to spend down until they were in poverty. They may have worked their entire lives to put together a little nest egg, and it is gone in a year or two.

I really applaud this initiative to look for some way that the private sector and government can work together to provide affordable insurance for people who are long-term elderly.

I am pleased that we are having this hearing, and I am looking forward to hearing the remarks of Mr. Bowen.

Mr. **Pepper**. Thank you very much, Ms. Meyers.

Mr. Kolbe.

STATEMENT OF REPRESENTATIVE JIM KOLBE

Mr. KOLBE. Thank you, Mr. Chairman.

I also want to commend you and your staff for holding these hearings beginning this process of discussion of what I think is one of the most important issues that we face today in our society, that is, providing coverage for citizens, particularly senior citizens from catastrophic health disasters.

When I was home during the last several weeks holding town halls, as I am sure many of my colleagues were, I heard from those senior citizens who have been either military retirees or Federal Civil Service retirees concerned about not having their COLA, of having it stripped away from them as part of our Gramm-Rudman deficit reduction legislation.

The issue of concern that I heard from them was that they still feel that inflation is eating away from their retirement. I think that is important because many of us looking at the consumer price index think that we are doing a good job of holding inflation down. But that area that has been the fastest growing remains the health care part of the consumer cost, which is still rising, although a little slower, faster than the rest of the consumer price index. For those the elderly, that becomes a particularly severe problem.

So, whether or not they are military retirees or Federal Civil Service retirees, all of the elderly are faced with the same problem of rising health care costs.

I think it is incumbent upon us as a society to address the problem of how catastrophic coverage can be provided for senior citizens so we do not lose our dignity in our old age and so we can continue to live our lives as senior citizens with some degree of independence and security in those waning years of our lives.

Thank you, Mr. Chairman.

Mr. PEPPER. Thank you, Mr. Kolbe.

Mr. Secretary, you can see from the statements made by members of our subcommittee how concerned we are about this matter of catastrophic health costs attending catastrophic illnesses.

We are immensely gratified that you at the very beginning of your new service to our country as Secretary of Health and Human Services have inaugurated a program with the support of the President to find a way to protect people against a greater number of catastrophic illnesses and costs.

Nationally, we may wish to go further than you, but we are anxious to hear you, because we know your heart is in the right place, as we say, you have the same goals that we have. You want to protect our elderly people particularly against destruction overall that they have by catastrophic illnesses.

We are very grateful to you, Dr. Bowen, for being here with us today.

As you all know, Dr. Bowen was a distinguished family practitioner. He was a distinguished Governor of Indiana. He is already a distinguished Secretary of Health and Human Services for our Government and for our country.

So, we welcome you here, Doctor, and we welcome your statement.

STATEMENT OF DR. OTIS R. BOWEN, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary BOWEN. Thank you.

Good morning, Mr. Chairman and members of the committee, I am honored by your invitation to speak here today, and I am pleased that my first appearance on Capitol Hill as Secretary of Health and Human Services is before the House Subcommittee on Health and Long-Term Care.

Chairman Pepper, your life is chapter and verse a wonderful chronicle of hard work and sacrifice dedicated to the public good. As the oldest member of Congress, you have a well-recognized and special interest in the needs of elderly Americans, and I am always willing to listen very carefully to your advice.

I would like to take a moment, even though I realize he is not here at the present time, to recognize the efforts of the ranking minority member of this subcommittee, Representative Ralph Regula. His compassion for our most needy and fragile citizens is a credit to this Congress and strikes the highest ideals of public service.

Today I will give you a brief overview on the status of aging in America, and I will touch on our study of catastrophic health care. I would point out, however, that we have not yet decided the parameters and timetables of this study. Following my presentation, Mr. Thomas R. Burke, my new Chief of Staff, had planned to be here to elaborate on my discussion and to answer questions, but he has been ill for the last 4 days and it is impossible for him to be here today.

Mr. Chairman, as a family practice physician, I have ministered to many of my elderly friends and neighbors in Indiana. I learned that, while good health was vital, most of them also were fearful of losing their independence. With this in mind, as Governor of Indiana, I labored to strike a balance between government serving the needs of people and government protecting their freedom and independence. I will work to forge the same balance at HHS.

Mr. Chairman, these are golden years, filled with hope for the future of our older Americans. Let me give you some examples:

A recent report released by my Department shows that life expectancy in the United States is at a record high. In 1983, the life expectancy at birth reached 74.6 years, roughly an increase of over 27 years since the turn of the century.

America's older Americans are leading healthier life-styles, and many have tremendous energy and vitality. The President's demanding lifestyle is a constant example of rigorous vitality. I am sure Chairman Pepper would be the first to agree that life does not stop at 65, and I am certainly glad it does not because in exactly 1 week I will be 68.

There are many reasons for these changes. Our Social Security system and public health care financing in the form of Medicare and Medicaid certainly have played a part. We must also give credit to a strong economy that bolsters investments and holds down inflation for those on fixed incomes, stretching the value of their savings.

It is in this spirit that the President's 1987 budget proposal calls for a full cost-of-living increase of 3.7 percent for those on Social Security.

Also, older Americans are receiving the benefits of new applications of technology. New technological achievements have made it possible to replace fragile hips and knee-joints. Innovative techniques now make operations more successful with less discomfort, such as new methods of lens replacement or implants which quickly improve sight.

In fact, many of our elderly are now going back to school to study the arts, philosophy, and the sciences. They are running for office, staying on the job longer, and contributing to our economy and culture in numbers that are unprecedented.

Our public policies must reflect these new demographic changes. We must have the foresight to adapt to an increasingly larger number of older citizens. Government programs, many of which were designed when the elderly population was smaller, must be examined to reflect these modern day demographics.

As more people live longer, health, social, economic, and other problems associated with aging change. For example, the demand for medical care is certain to rise.

It is estimated that the elderly will make about 230 million visits to physicians annually by the end of the century. There were about 165 million such visits in 1980. The projected increase is about 40 percent. This shows graphically that, although the numbers of elderly will increase steadily, the projected costs of health care will increase geometrically.

The potential impact on hospital and nursing home care is even greater. Persons 65 years of age and older may use about 160 million days of care in short-term hospitals in the year 2000, a gain of 55 million days over the 1980 level. This increase in utilization is over 50 percent.

We have had almost a generation of experience with most of our Federal health and human services programs. We can now measure the ideals of the legislation versus the reality of its operation. We now have empirical evidence that contrasts our intentions with factual results. This is why the President called for two important studies affecting my department.

First, in the State of the Union address, the President called for an examination of how the private sector and the Government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes. We are enthusiastic about his charge to examine the entire question of catastrophic illness costs, including possible actions for both the private and public sectors.

The second study, an examination of welfare policy, is equally important, and will be the subject of considerable scrutiny.

Our work is now just beginning. This hearing, and your interest, could not be more timely.

I want to thank you again for this opportunity to speak briefly with you.

Mr. Chairman, I would like to have Mr. Burke's statement submitted for the record and respectfully request that in Mr. Burke's absence I be permitted to submit answers in writing to any questions that any of you might have.

[Statement of Mr. Thomas R. Burke follows:]

PREPARED STATEMENT OF THOMAS R. BURKE, CHIEF OF STAFF, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman, I would like to thank you, Representative Regula, and the distinguished members of the House Subcommittee on Health and Long-term Care for allowing me the opportunity to discuss the problems of catastropic illness costs, and the commitment by the Reagan Administration to seek appropriate solutions to this multi-faceted problem.

Mr. Chairman, I'm sure all of us will agree that no American ought to face financial ruin because of the necessity of medical care. But, beyond that assertion, there is very little consensus about how to accomplish this task.

In fact, there is often little agreement on what constitutes a catastropic medical cost.

For example, some have defined it as a large aggregate dollar cost, perhaps $20,000 and above. Others say it depends on the size of patient out-of-pocket expenses, somewhere above $2,000. Still others relate it to the cost incurred and the individual's income.

While each of these definitions has merit, they often do not take into account such important variables as net worth and outstanding indebtedness.

Mr. Chairman, I know that the members of this Subcommittee are aware that health care can be very expensive. For some a hospital stay can cost tens of thousands of dollars, and often run into the hundreds of thousands of dollars.

The cost of any illness that entails long-term care may be even greater. For example, in 1982 Americans spent $27.3 billion on nursing home care, and we estimate that this figure will soar to $82 billion by 1990. And consider this: unlike hospital care, little of the cost of nursing home care is paid by private insurance. While 45 percent of the 1982 nursing home bill was paid from private sources, only 1.6 percent came from insurance.

Parenthetically, almost half of the total nursing home care costs, over $13 billion, were paid by Medicaid.

The need for long-term care may drain precious savings away from the elderly and their families, and some may lose a lifetime's struggle for financial security and independence.

In addition, once expensive care is required the need rarely diminishes; one-fifth of the affected families will experience large medical expenses once again in the next year, and most will do it again a third year.

Even if those who need care hold on to some of their savings, no one can predict when debilitating illness will strike. Many of our elderly live in fear, waiting for the nightmare of catastrophic illness to wipe them out.

Of course, many have private insurance, and they are wise if they have coverage for catastrophic care. However, too often catastrophic care is not a part of the policy, or coverage is too limited to be adequate.

Within the Medicare population alone, each year approximately 12,800 beneficiaries exhaust their lifetime reserve days for hospital coverage and 280,000 beneficiaries experience hospital stays which exceed the 60-day limit at which point large cost-sharing begins.

Let me amplify the problems faced by the beneficiaries. Private insurance goes part of the way in picking up coverage after Medicare leaves off; 50 percent of beneficiaries have full coverage after the expiration of the lifetime reserve days, and 15 percent have partial coverage through private insurers. In addition, 58 percent of beneficiaries have private coverage cost-sharing after the 60th day in the hospital.

But this still leaves a small minority with little or no coverage for extended hospital stays.

This problem can only get worse with the "greying of America." An estimated 6.6 million Americans 65 years of age and older now require long-term care, and that number will reach 9.3 million by the end of the century. This trend will continue geometrically.

Many elderly people think they are fully protected by Medicare. But Medicare covers only a portion of the costs of acute hospital care and physicians' services for those 65 and over, and does not cover long-term care.

Mr. Chairman, we are faced with a new and sobering challenge: to discover better forms of coverage. We must find forms of coverage that are efficient and encourage quality care without sacrificing efficiency, that are affordable for the American tax-payer, that will not further deplete older Americans' savings, and that will not add to the current Federal deficit problem.

Mr. Chairman, the President has asked in his recent State of the Union address for Secretary Bowen and the Department of Health and Human Services to report by year's end with recommendations on how the private sector and Government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastropic illness strikes. This is a challenge that we welcome.

The President's charge is a clear indication that the White House is willing to work with the private sector, with other levels of government, and with the Congress to explore innovative, creative and serious proposals for catastropic care coverage.

Secretary Bowen and I have a keen interest in this subject. It is one we discussed when Dr. Bowen was Chairman of the President's Advisory Council on Social Security, and was the subject of an article we co-authored before the Secretary was asked by the President to assume the mantle at HHS.

In that article, we considered an optional plan to add a $12 a month premium to the $15.50 monthly premium already charged for Medicare coverage. Expanded Medicare coverage would ease the strain on individual participant's savings, and take some of the fiscal pressure off the Medicare program.

A second part of that proposal would establish Individual Medical Accounts (IMAs) for financing chronic care expenses. This concept, based on the success of Individual Retirement Accounts (IRAs), would allow tax-deferred contributions to a government "health bank " administered by the private sector.

As I stated, Dr. Bowen and I made that proposal before the Secretary was confirmed. We plan to treat it as a proposal worthy of intense examination, but we are not recommending its passage at this time. It shall be considered in light of the President's broader charge to examine the role of the private and public sectors in providing catastrophic coverage.

We are not locked into any proposal. I know that Secretary Bowen plans to examine all of the available information, scrutinize every proposal, and consult this Subcommittee, other members of Congress, medical and consumer groups, and others in the Administration before he formulates his final report to the President.

That is why these hearings are important. We are looking to the Congress to help us gather information. We plan to listen very closely to the testimony presented here, and we will have an open mind as we examine all alternatives.

Thank you for the opportunity to share a few moments with you this morning, and I commend this Subcommittee for its diligent and compassionate work to highlight one of our most important national concerns.

I will be happy to respond to any questions you may have at this time.

Mr. **Pepper**. Thank you very much, Doctor, for your excellent statement.

May I be sure and clear in my mind, your proposal has not yet been particularized? You have not yet submitted the details?

Secretary **Bowen**. That is right.

Mr. **Pepper**. You are engaged in a study about the matter?

Secretary **Bowen**. Yes.

Mr. **Pepper**. We would hope, Doctor, that while your proposed beginning, as indicated by the President and by information we received, is a very good beginning, commendable on your part and that of the Administration, nonetheless, as has been indicated by members here, we are troubled by such cases as that of a lady whose mother used to work for me in Miami who came to my office one day and said:

> Mr. Pepper, if you look at my eyeballs you will see they are already turning yellow. I have a liver disease. They tell me I will have to have a transplant in 6 or 9 months, or I will be dead in 12 months. They tell me it will cost at least $150,000 for me to be able to get that transplant, maybe even more. I will be able to raise $45,000, and that's all. Can you help me?

I got in touch with Mr. Stockman, who was the Director of the Office of Management and Budget, who knew more about the Government than anybody, in my opinion.

"Do you know of any help, Mr. Stockman, for a citizen in this situation?"

"No," he said, "I don't. I will check."

He called me back and said, "No, I don't know of any governmental program that will give that lady any help."

To make a long story short, she received a donation of a liver from some person in Texas. She raised $180,000. The operation was performed by the Baptist Hospital in New England, one of the major New England Boston hospitals. It was performed at less than the usual rate that they charge.

She was fortunate. Several of us helped her to try to raise that money. She was fortunate indeed. Very few people would be able to raise that amount of money.

She had the operation. She, so far, is doing very well, and we have her statement here. I will not keep you. I had hoped your assistant would be here so he will hear it later. Her statement will be read at the hearing here today.

What we are concerned about are many people like her and thousands and thousands of others who need transplants, who have Alzheimer's disease, have one type of catastrophic illness or another that is ruining them in its cost to those individuals.

We are hoping that in your study it will be within the scope of the President's language in the State of the Union address, that it will study comprehensive coverage, not just those who might be able to stay longer in a hospital, because if you just limit the application of the principle to those, only about one tenth of 1 percent of all the elderly people would be the beneficiary.

In your study we would very much appreciate it if you would include comprehensive coverage and let us see if that readily will be made of setting up a system that will provide such coverage, using to the maximum private resources, private enterprise, private administrations, and the like, cooperation in the finest way between government and private enterprise and, of course, with fairness to all the providers who were involved in the matter.

So, we would appreciate it if you would in your study include comprehensive coverage for all catastrophic illnesses.

We are contemplating introducing legislation that will be comprehensive in its coverage, that will give us a basis for our study, also, and will be in the direction in which we are seeking to move.

So, I want to personally thank you very much, Doctor, for what you have done and for what you mean to encourage people in the country to believe that our Government is working toward trying to protect them against catastrophic illness.

Secretary **Bowen**. Mr. Chairman, I am acutely aware, not only of the problem, but of the need. And, the need is going to continue to increase since we have other technological procedures and also an increasing number of aged.

I am sure you are familiar with the paper that was written by Mr. Burke and me concerning catastrophic care, both acute and long-term.

The President's State of the Union Address broadened our charge, and that is why I say we are not ready now to speak to the parameters.

The charge, of course, would include finding a means of providing catastrophic care for the Medicare age group for acute type of illnesses, prolonged hospitalization, for example, and then addressing the Medicare "gap" for long-term nursing home care.

I have a mother who has been in a nursing home now for a little over a year. So I am acutely aware of that because I know who pays the bills.

Then, our study was also broadened to include the non-Medicare-age group, such as the type that the Congressman mentioned with the premature child who continued to live with good medical care, but with rising medical expenses.

So, we will be looking into all of those. As I mentioned earlier, I will look forward to working with you and the committee to try to solve those types of problems.

Mr. **Pepper**. Doctor, I feel that the marketplace is doing a great deal toward developing techniques, means, and measures by which we hope some day, and I hope the good Lord will let me live long enough to see it, by paying whatever he or she can and should, that every man, woman, and child in America will be able to get the medical care that he or she should have.

Human life is a very sacred thing, and if we have the means to preserve it we have a measure of moral responsibility for seeing it along, because that individual doesn't have the money to pay for the technology and the facility that would prolong that life. I think we have to come to grips with that.

I feel like you have an open mind in this field. We are not talking about socialized anything. We are talking about Americanism showing compassion, developing means and measures and methods by which we can allow people to get the medical care that they should have. We want it primarily to be centered around private enterprise, expanded operation of insurance companies on the part of people who are interested in rendering this kind of service to their people.

I think the marketplace is demanding that we do something like that, and I hope we are making progress in that direction.

Mr. Wyden.

Mr. **Wyden**. Thank you very much, Mr. Chairman.

I also want to echo, Mr. Secretary, Senator Pepper's comments about your good heart and open mind. I think that is well known.

I really want to ask some philosophical kinds of questions by way of getting to what I am thinking about. I know you have presented detailed plans, and I think it is good to have you with us.

First is the point I made in the opening statement. How do you reconcile what appears to be a pretty clear contradiction between a proposal for $60 billion in Medicare and Medicaid cuts over the next 5 years with an interest in expanding a benefit in this case to catastrophic care? I am glad that you want to go forward and do that. I would be interested in how you reconcile what I think are really savage cuts in the budget with wanting to expand into a new area.

Secretary **Bowen**. I do not think they are totally incompatible. I would hate to think that any system in government could not be made a little more efficient.

Of course, our Department, along with other departments in government, is under a mandate to cut back, as you very well know.

So, I do not think they are incompatible. I think that comprehensive long-term care and catastrophic care can be made cost neutral, the theory being the Federal Government would really be providing adequate and decent care without the catastrophic costs to the beneficiary that might go with it.

Mr. **Wyden**. I must tell you—I just have a couple of minutes so I will not elaborate—that I think both the consumers and providers feel that the proposed cuts go way beyond cutting inefficiency and are really cutting the meat not just the fat.

I am glad that you think that they are not totally incompatible, and we are going to work with you to utilize our resources in the best way both with existing benefits and the new approach to catastrophic care.

Secretary **Bowen**. It is going to require some innovative and creative thinking.

Mr. **Wyden**. It will, indeed.

A couple of other questions very briefly: The one thing that runs through your thinking with respect to catastrophic coverage is that it would be an optional kind of arrangement. You could pay if you chose to do so, your medical IRA concept is an optional one.

I wonder, are you concerned that a lot of seniors will be left behind with that kind of approach because they simply will not be able to afford medical IRA's or catastrophic coverage?

It seems to me again that these people of modest means who are here today to testify would be left behind.

I wonder if you are concerned that this kind of approach will leave some of the seniors—in fact a lot of seniors—on modest incomes behind.

Secretary **Bowen**. In fact, as you know, those of senior age worry about finances and health and which one is going to run out first. I think most of the people do have their priorities straight and do not want to have their entire savings wiped out by some catastrophic type illness.

So, I think the elderly priority on that type of future investment for their health would be pretty great. I am referring especially to the long-term nursing home type of catastrophic care that one could choose to fund through some type of an IMA, on individual medical account, which is like an IRA. Individuals would pay into it in their highest earning years, perhaps ages 35 to 55. There have been actuarial studies that the majority of the people would do that.

Obviously, those who would not do it then would run the risk of losing a great deal in the event that they did have some catastrophic type of illness. We still would have the Medicaid program to fall back upon which, of course——

Mr. **Wyden**. The other question I wanted to ask very quickly with respect to the catastrophic proposals, it seems to me that you are saying that you have to be in a hospital for over 60 days to be eligible for catastrophic coverage. Now, less than 1 percent of patients, for example, are in hospitals for more than 60 days.

Is that something that you are very much committed to, or would you be willing to make modifications in that because particularly with the prospective payments system, as you know, the length of stay is decreasing? It is only 1 percent, for example, as far as I can tell would even be eligible for your proposal.

Secretary BOWEN. The other 99 percent are worried that they are going to be in that 1 percent sometime.

Mr. WYDEN. Correct.

Secretary BOWEN. So, I think that has to be taken into consideration.

When the Advisory Council on Social Security made its report, there were about 300,000 a year from the Medicare population who had their earnings essentially wiped out by prolonged hospitalization.

Mr. WYDEN. Are you pretty much fixed at 60 days, that it ought to apply to people in a hospital more than 60 days?

Secretary BOWEN. The proposal we recommended in the article I mentioned, would provide unlimited numbers of hospital days.

Mr. WYDEN. But you would have to be in a hospital more than 60 days under what you have discussed in the past. I just wondered by way of your approach whether you are committed to this or if there is some flexibility there.

Secretary BOWEN. Remember that paper was prepared in 1982 or 1983 shortly after we finished the advisory council on Social Security's study of Medicare. That was long before I had any idea I would be sitting in a spot like this.

But I am not wedded absolutely to anything. As I said earlier, we are happy to work with this other committee to try to establish a reasonable form that would be of benefit to all of our senior citizens.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. PEPPER. Members of the subcommittee and to the Doctor, I apologize. It slipped my mind that you told me about the emergency of you needing to leave after your statement, and I promised you we would allow you to do so. It slipped my mind. We ordinarily ask questions of witnesses afterwards.

I am going to keep my promise to you to excuse you now. You said you had some pressing matters. The Doctor has assured us that any questions you send to him he will be glad to answer. For anybody who wishes to address questions to the Secretary he has assured us he will attempt to answer them.

Ms. OAKAR. Mr. Chairman, I know one question I am going to ask him in writing is whether or not he still agrees with the Bowen commission report in 1982.

Mr. MCCAIN. Mr. Chairman, I have a number of questions I am going to submit in writing, and I would be glad to articulate them also if you would like.

Mr. PEPPER. I think any member who has any questions should submit them to the doctor.

[See Appendix, p. 61 for answers to questions submitted by Chairman Pepper and Representative Oakar.]

Secretary **Bowen**. I would like to respond to the Congresswoman's question.

Our charge in 1982 was to find a way to rescue a very ailing program, Medicare, which was projected to run a deficit of between $300 billion and $500 billion by 1995.

Your actions in Congress to approve the prospective payment system have changed the situation considerably.

I think my mind would be a little bit set differently than it was at that time. But I stand by the report as a reflection of the situation which existed at the time of the study.

Ms. **Oakar**. So, you do not think you should raise the eligibility——

Mr. **McCain**. A point of order, Mr. Chairman. Are we going to have questions or are we——

Mr. **Pepper**. No. I promised the doctor that we would excuse him.

Ms. **Oakar**. Thank you.

Mr. **Pepper**. Doctor, your chief of staff was scheduled to appear. He is ill and not able to be here.

Secretary **Bowen**. He has been ill for the last 4 days.

Mr. **Pepper**. Will your assistant who is here with you today testify?

Secretary **Bowen**. No.

Mr. **Pepper**. Very well. We are sorry that your chief of staff was not able to be here, but your assistant is going to remain here for the remainder of the testimony?

Secretary **Bowen**. Yes.

Mr. **Pepper**. Thank you very much, Doctor. We appreciate your being with us today and look forward to working with you.

Our next panel are victims of catastrophic illness starting with Edward Melament, a husband of an Alzheimer's victim who lives in New York City; Edward Howard, 71, a stroke victim from Upper Marlboro, MD; Mrs. Candida de Croce, the wife of an Alzheimer's victim, and she lives in Washington, DC; Mrs. Natalie Hall, the daughter-in-law of an Alzheimer's victim from Arlington; Mr. John Burns, postal inspector; and last, Mr. X, a former insurance salesman convicted of selling bogus Medigap policies in Massachusetts.

While the witnesses are taking their seats, one other member of our subcommittee has arrived, Mr. Vento, and he wishes to make a statement.

STATEMENT OF REPRESENTATIVE BURCE F. VENTO

Mr. **Vento**. Thank you, Mr. Chairman. I appreciate the opportunity to participate in this hearing this morning.

I want to commend you for your excellent leadership again in 1986 just as was your work done over the years to try and focus attention on the problems facing older Americans.

This issue of catastrophic health, of course, is one of the fundamental problems because I think it raises questions about the promise of Medicare, whether indeed Medicare will do the job it was intended to do in terms of covering the health care needs of older Americans.

Today more than ever Medicare covers a decreasing percentage of the health care needs of older Americans. The efforts Congress has made to make the system more efficient and more effective is certainly something that needs continuing oversight and investigation.

Certainly the issue of catastrophic care, in other words, going beyond and fulfilling the promise of Medicare, is a very important one in terms of limiting the problems and eliminating the fears that older Americans face with regards to their health care needs.

Nothing I think as a society is more important than dealing with catastrophic illness protection. I think that catastrophic health protection as it affects older Americans is particularly important, but it is also important for many other generations of Americans as well as the elderly.

Mr. Chairman, I am pleased the President has asked for a review of this particular issue. He has long held court for a catastrophic health program. It is one that has alluded policymakers in Washington and many States for a long time.

The fact is I would be much more pleased if he had put forth a proposal to actually take action on the issue. Although he has done that in the past, he has done it in such a way that he has unduly burdened the other elements of health care programs such as Medicaid to provide particular benefits but exclusively to the elderly.

In my own home State of Minnesota, Mr. Chairman, we, in fact, put in place a catastrophic health care plan. We, in fact, put in place a program that provided for a surcharge in almost all private and nonprofit insurance companies that, in fact, for a small cost provided the catastrophic health plan coverage which, in fact, had a contribution left from the individual that received that benefit. That was in place.

Then under a different administration it was removed. Now I am happy to report, Mr. Chairman, under Gov. Rudy Perpich, that catastrophic health care plan has been reconstituted and is serving the needs of not just the elderly but all of Minnesota.

So, I think we have a number of models to look to, and I hope in your investigation and consideration and the staff's review of this that indeed they will look at some of the States that have instituted successful health programs to address catastrophic illness, and that we will, indeed, as a Congress and as an administration move toward providing a realistic and effective catastrophic health care program for the elderly as well as the general population of citizens in this country.

Thank you.

STATEMENT OF EDWARD MELAMENT, NEW YORK, NY

Mr. **Melament**. Members of the subcommittee, ladies and gentlemen, thank you for affording me the chance to tell my story.

I have a statement that I am going to submit, but I will try to read from it. I may wander a little, but I know that time is a precious commodity. I will try not to wander too far.

First, I would like to give you a short history of the situation I find myself in. I am here, incidentally, in the hope that my personal experiences in trying to care for my wife, who has Alzheimer's disease, will help bring about needed reforms to limit the emotional and financial devastation which is customarily associated with this kind of illness.

My wife's catastrophic illness—I guess I will term it that—started about 17 years ago. She is still with us physically. That is about all.

She started to lose things, misplace personal items, and her ability to read, write, speak began to deteriorate. This is back in 1969, 1970.

Along about 1974 after we had seen numerous doctors, neurologists, psychiatrists, acupuncturists, you name it, we were sufficiently concerned so that she was willing to go to a hospital for a diagnostic checkup. She was there 2½ weeks, during which they examined every inch of her to determine whether she had any organ damage, any deficiencies which might mimic the characteristics of Alzheimer's disease, because there are organic things that can do it, even medications.

Well, it is interesting during this process we had an intern who spoke to me and said, "Hopefully she will have a brain tumor that is operable," and I began to realize how serious the matter was.

After 2½ weeks, the neurologist of the hospital and the internist spoke to me, and they said, "You can take her home now."

I said, "What's going to happen?"

"Oh," they said, "she will just keep deteriorating and she will die."

I said, "What's the timeframe, when?"

They said, "About 10 years from the time it began." This is 1974. I didn't know when it began.

I took home this person who physically was robust, who still was communicating, and I had a death sentence, and she was all of 53 years of age. I was in my early fifties.

Well, she continued to degenerate, and then—well, I will go quickly to 1980 just to get the point across.

In 1980, one morning she did not know me. She simply just did not know me any more, and she was gone as far as I was concerned. It is pretty hard to describe adequately the kind of emotional erosion you get when you have a person that you have known for 35 to 40 years, has been supportive, productive, has been a good mother, wife, still looks as well as she ever did, and no longer can communicate with you, no longer knows you.

In her earliest stages when I first began to feel the terrible emotional traumas that were occurring, I remember one night going to bed and she did not cover herself. It was wintertime. I said, "Cover yourself." She did not know how to cover herself.

There were times we met lifelong friends and she did not remember them, and when we got home she would ask who they were, and I told her, and she would just break down into tears and just cry for hours.

I just want to do one illustration. There are so many anecdotes I have in my repertoire unfortunately, but I will give you one to illustrate the kinds of emotional erosion that a person like myself goes through.

My daughter was undergoing an operation, a serious operation, and my son-in-law and I walked the corridors as people do during an operation. She recovered; she did all right, but months later my son-in-law and I were having one of those heart-to-heart talks, and he said to me, "Dad, remember that day at the hospital?" I said yes.

He said, "You know, you know how panicky I was?" I said no.

For the first time it occurred to him he could lose her. He was all of 28 years of age. She was 27. They were married 6 years.

He said, "She could have died. I could have lost her."

I said, "David, I understand. Every night when your mother-in-law and I go to bed and she just gets out of bed because she will not stay there and walks the house, and I trail after her, bring her back to bed, and she will get out again and I bring her back, and along about 4 a.m. she will fall asleep for a while, and I will, exhausted, may sleep for 2 hours. And I get up, groggy, and I look at her and there she is. She looks just the way she always did. For a moment I will forget, and I will say something to her. She will respond irrelevantly, and then I know I have lost her.

I said, "David, I lose her every day."

Well, early in my wife's illness I was still at the peak of my career, early fifties, call it a peak. I was a school principal, but you get to be kind of irrational when you see your companion of so many years going down, and you just cannot think of working. And I began to plan retirement. That is a heck of a note, and I actually did retire, because at the age of 55—and I come from New York City—the pension is full pension. They call it full pension, and at that time it seemed pretty adequate so that I could take care of her for the rest of our days.

Then I was persuaded to take a job with a private school as a principal because it was in my locality and the owner said to me,"We understand the situation. You can go home when you have to, call and so forth."

I took that job, but after about 2 years, in 1978, the erosion physically and mentally had taken effect, and I had a heart attack. I was not really a candidate for a heart attack. I did not have any of the characteristics that would call for it, but I did.

After 3 weeks, I got home from the hospital and there was a woman companion for my wife. Up to this time I would never have allowed it because another characteristic of a caretaker is you are not going to let anybody do it for you.

Maybe it is obligation, responsibility, maybe it is just guilt, but I was not going to let anybody do it.

But now I had to, and I hired this woman on a 5-day, 8-hour-day basis, and I think at the time the cost was probably only about $400 to $501 a week, quite a bit for the kind of savings I had but something I thought I could manage.

Unfortunately, I was not doing so well myself and my wife was deteriorating further. Now, there comes a time when like children maturate and Alzheimer's victims dematurate. My wife was approaching the child stage. She could no longer dress herself. She could no longer feed herself. She could not speak. She could not read. She could not write. She could not communicate.

I was finding it very difficult to deal with it emotionally and physically, and having discussions with my daughter we agreed to get 7-day help around the clock. Well, 7-day help around the clock can cost something like $1,000 a week. I did not have that.

About that time I had been recruited in a family support group for Alzheimer spouses, and it is the one good thing to have. We had a fine support group. That is 7 years ago, and I am still participating.

You learn a lot. Besides getting catharsis, listening to other people's similar situations, you get a lot of advice. One of the bits of advice I got was to consult legal, and I did get a knowledgeable person, and he told me, "You keep her at home and it will cost you whatever it is going to cost you, but you are not getting anything back. It is not a medical condition, Medicare will not cover it; private medical insurance will not cover it."

I asked about a nursing home, and he said that a nursing home may not cover it either.

Anyway, a strategy we employed was to place her in a nursing home, which is also a problem because nursing homes are not too prone to take Alzheimer's patients. But we did place her, and for 6 months I paid, and it cost me $16,000 for 6 months.

In New York where I come from nursing home costs run from $30,000 to $50,000 a year.

During that time I filed an application for Medicaid for her. She was finally adjudged eligible; however, my responsibility was there, and they proceeded to evaluate my assets and income and my budget. They arrived at a budget for me, and when they finally arrived at a budget, what contribution I had to give was over one-third of my pension and Social Security.

With the balance I have to take care of a 50-year-old house which I got 20 years ago and I still have a mortgage on it. I have to take care of my medical problems. I have to take care of my daily needs.

I assure you I have a rather meager existence. For someone who worked as a professional for many years, who saved frugally, who thought he was going to have a fairly comfortable golden years' existence, I assure you it is not comfortable.

Yet, I am probably better off than literally millions of others who have not had the advantage of a good support group or a supportive family or even the means I have.

I said for the last 8 years, 7 years I have been with a support group, and this group which is an excellent one we had some 20 to 22 people during that period. We have lost a few through death, leaving, and we have some new ones, but most of the members are originals.

Out of the 20, 22 people we have had four heart attacks, three nervous breakdowns, a lot of high blood pressure, operations, a lot of despair.

It is mentioned that there are 4 million victims of Alzheimer's disease. That means there is logically one primary caretaker for every Alzheimer's victim.

Now, everybody understands who are the Alzheimer's victim and you sympathize with them, but not so many people understand the problems of the caregiver.

Now, the Alzheimer's victim is not going to get better. It is unfortunate, but it is true. But the caregiver can get better. He is not likely to, because if you have all that emotional erosion and being a senior citizen and you are facing this terrible catastrophy in a financial way, how are you going to cope with it?

I know when I was young and upwardly mobile and was a young teacher and had a small income, if I had a financial problem, I got jobs at night or I worked the summer, no problem.

How do you do that when you get to be in your sixties?

I will give you an example of somebody in our group, a dentist, very successful person, right, a person of means. He retired. His wife was only 60 when she came down with Alzheimer's disease, and he joined our group and was in a terrible emotional state because of just observing this formerly productive person that he knew going down the drain.

Although he found the group helpful and he was known to say, "This is my fix. I come here every week for my fix." Physically and mentally he went down the drain just like all the rest of us, and 2 months ago he had a heart attack.

He was in the hospital for 3 weeks, and a couple of weeks later he came in with a helper, came to see us, and we tried to find out what was going on, and this is the story.

When he came home, he had to get around-the-clock help. That is 7 days around-the-clock. He had had part-time help before. He says he is paying over $1,000 a week for that help.

He is also paying for help for himself because his health is bad. Fortunately most of his personal expense is medical so he has private insurance Medicare.

But his wife is physically fine, there is no compensation for that. He says he has a $50,000, $60,000, expense coming each year, and he said, "Where am I going to go?"

The point I am trying to make is that people like that—and he is a fairly well-to-do person—people like that are just not going to survive.

I know this from my own experience. I know that I must have been very close to not surviving. I know there are millions of people who are anonymous who do not have support groups, do not have the support of families.

In New York City we have these high-rise buildings. There must be thousands and thousands of people up there isolated, no friends, little family support, taking care of an Alzheimer's spouse going down the drain. They are not going to survive.

So, this is what I am asking. It is what I am here for. I am not an expert in finances, so I have no specifics, but I say there must be a mechanism, and the members of this subcommittee have to be the experts. There must be a mechanism to find a limitation on how much a person will have to spend before assistance can become available.

I am not talking about a handout. I am talking about people who have saved all their lives who have been frugal, who have been thinking about a rainy day and now find themselves facing poverty, destitution, and are in no position emotionally to face it.

I hope you can find a way to help us help ourselves because we have to survive with some kind of dignity.

Thank you.

Mr. **Pepper**. Thank you very much, Mr. Melament, for your stirring story.

Mr. Howard is next.

STATEMENT OF EDWARD HOWARD, UPPER MARLBORO, MD

Mr. **Howard**. I am going to read from the statement to save a little time.

I am 71 years old. I am from Upper Marlboro, MD. I am here this morning to tell you about the horrors that can come when serious illness strikes.

Well, back in 1973, I suffered a severe stroke that paralyzed my entire right side. I was 58 years old then, strong and productive, and all of a sudden I was unable to work or even write my name, since I am right-handed.

My wife and I got by pretty well for a time, with a combination of money from Medicare and a little of our savings, until suddenly my wife became ill in 1977 with cancer. Her condition was complicated by numerous fractures and pneumonia.

She died in April 1984. Obviously, her death brought terrible emotional trauma to me, but the period after her death brought another staggering realization.

One day I looked around and it really hit—Hey, fella, you are all alone. It was a startling discovery.

I tried as best I could to deal with my wife's uncovered medical bills, which at the time of her death and very shortly thereafter totaled $17,000.

To date, insurance has only paid $64 of this bill. Can you imagine? Aside from Medicare, I am insured with a prominent senior organization and I hold policies with two other large insurance companies. Yet I was told I had to pay out of my own pocket $16,936 on that bill.

After that and possibly as a result of that my own health deteriorated. I had to have repeated surgeries on my foot and then my leg due to poor circulation as a result of the stroke. Gall bladder and prostate surgery followed. It seemed as though everything broke down at one time.

During all this, and my convalescence afterwards, I became very depressed. I felt as though I faced a brick wall, with no conceivable way over or around it. I lost 75 pounds, so my weight fell to just over 100 pounds, and as you can see I am a pretty tall fellow.

I could not think of too many reasons to continue with my struggle to live. Fortunately, Home Call, a home health agency that had helped my wife and I in the past was there to help again.

When they started visiting me, I was entirely dependent on home health aides for all my care. I needed round-the-clock care, 24 hours. They bathed me, cooked for me, provided therapy, administered medication, talked to me, teased me, and finally got me eating again, because up to that point there was nothing there for me—so, they got me eating again and basically provided the good human contact that I needed. With their assistance, I started doing things for myself. It was a painful battle but one I am glad I fought.

I cannot say enough good things about the Home Call staff. They were great. However, after I received the first bill for their services, I started to panic. The charge for 2 weeks' care was $3,500. I could see that it would not take long for my savings to run out. Well, that is just about what happened.

Fortunately, I am feeling a little better now, physically and emotionally, and can do more for myself, but I still need help 8 hours a day for 5 days a week. The other times I get by as best I can. I know I am running out of money for this care, but I also know how important it is that I get it, the care.

I have teetered very, very close to the edge of depression before, feeling hopeless and also missing out on the kind of care I so desperately need, to take that chance again. And it is a chance to try to pull myself up when you get knocked down by a serious illness.

So, here I am, in the unfortunate situation of having spent nearly all of my life savings on health care, and still having to worry every night when I go to bed and every morning when I wake up that the last few dollars will soon be gone. I honestly thought I was well insured and protected against something like this happening, but here I am with four insurance policies and, because of the nature of my needs and the terms of the policies, none of them did any good.

In the past 2 years, I have spent nearly $100,000 over and above what Medicare has paid to take care of my medical bills. So, what happens next? I do not have the resources to continue that kind of payment.

In the past 2 years, I have had no cooperation from these insurance companies when I explain to them that it is impossible for me to come in with my claims and that, for the time allotted to me to file them, I was too sick, too incapacitated to do these sort of things.

I am pleased to be here today to tell the subcommittee members and others assembled here how terrible it is to be in this position. I thought I had it all sewn up, that I had provided for myself for the rest of my days. It is amazing to me that my insurance policies do not help a bit.

The small contribution of 2 hours three times a week of home care that Medicare covers does me about as much good as giving a starving man a penny and saying, "Go, feed yourself."

Please consider the many needs and services required in the face of a calamity like this. I hope those of you in the Congress, with your experience and skill, can think of some way of fixing the current situation.

I know no one would welcome that development more than I.

Thank you.

Mr. **Pepper**. Mr. Howard, it is because of you and others like you that we are looking at this area today and the reason our committee has been working for years to try to develop some way to take care of such situations as yours. You have made a deeply moving statement.

We will take a 5-minute recess and be right back.

STATEMENT OF CANDIDA de CROCE, WASHINGTON, DC

Mrs. **de Croce**. Thank you for inviting me here to testify. I beg your indulgence in my reading. I was born in another country, and even though I am an American citizen I did not grow up here.

I have been married for 10 years to a wonderful man. Unfortunately, he has been stricken with many illnesses which I would term catastrophic.

He is with me today, but I asked that he be taken out of the room while I tell our story.

Several years ago, my husband developed a circulation problem in his leg which led to severe pain. A bypass operation was performed, but it was unsuccessful. The problem produced a gangrenous leg which had to be amputated.

He has suffered from an abdominal aneurysm, which was removed in major surgery. To keep a check on these problems, he must undergo each year a colonoscopy and a cystoscopy.

These are expensive procedures. Medicare covers part of the payment. All these ailments seem like more than enough for one person to bear. However, there was something else to come. Two years ago, my husband and I went to Mass on a Saturday, as we always do. Before we entered the church, my husband discovered he had forgotten to bring some checks we were going to use for errands at the pharmacy and the supermarket.

My husband said he would go home to get them. I waited outside the church, but he did not come back. I went home, and he still did not appear. He was missing for about 2 hours. The poor man had forgotten where he was. He was visibly shaken when he got home. I myself was very disturbed. I decided to send him to a doctor to get a diagnosis.

A CAT scan showed atrophy of the brain, which is a symptom of Alzheimer's disease. In a short time I noted other Alzheimer's-like behavior. He could not retain information. He would become incoherent. I noted small signs of deterioration with each passing day.

Medicare helped us with some of the other illnesses I mentioned, but it does practically nothing for Alzheimer's. Medicare does pay for our visits to the doctor, which have a $146 price tag. Yet, my husband's doctor does not accept assignment. We are obliged to pay anything beyond what Medicare can reimburse, meaning we pay about $86 above the $60 or so Medicare pays.

If and when my husband needs a nursing home or custodial home care, Medicare will not pay. I suppose we will have to spend ourselves down to poverty so we can become eligible for Medicaid. Our home will have to be sold. I do not know where I would live.

We are making out all right for the moment. I work as a secretary at the Department of Housing and Urban Development. My husband has $500 a month coming in from Social Security, and my paycheck brings in a little more than that. More than half of that a month goes toward payment for our condominium apartment.

My husband spends each weekday at the downtown center for Alzheimer's victims so I can work. A bus picks him up in the morning and delivers him home safely at night.

For about 3 months I had to take 2 hours of leave each morning to stay with my husband. He began to wander and I was afraid he would get lost or be hit by a car. Now I have hired a person in our building to be there with him in the morning to see him off.

I had to fight to have my husband admitted to his current program; our house was not on their main bus route, and they did not like the idea of picking him up. With the assistance of the D.C. Office on Aging we worked things out.

The center only handles early stage Alzheimer's patients. I had a terrible scare recently when my husband became incontinent. The center is not prepared to handle that, just as they cannot handle loud or unruly Alzheimer's patients. My husband's physician said he could equip him with an external catheter so he could perhaps continue at the center.

However, the doctor thought we ought to send him to a urologist. Thank goodness, the incontinence problem was the result of an infection. The infection was treated and the incontinence went away. However, this jarred me. If he had a bad problem with incontinence, he would be asked to leave the center. I would have to quit my job to care for him, which would spell our financial ruin.

I am a realist. I know my husband's condition is likely to deteriorate. I have begun to look into the nursing home situation. Nursing homes are much more expensive. If we had those bills, I do not know what we would do. I would like to put my husband in a very nice home I know in Maryland. It is run by the Carmelite order, whose central purpose is service to the elderly. It is very costly, and there is a long waiting list and Medicare would not pay for his care at home, nor would our private insurance.

I thank God each day. I am 24 years younger than my husband, so I have the physical strength to help him. A woman his age simply could not take care of him. I am able to keep working, so we have an income beyond my husband's Social Security. For now, we are making it.

I was born and raised in Italy where the family is very important and elderly people are looked up to and revered. You might almost say they are worshipped there. I was in for a rude awakening when I came to this country.

Families like ours who are trying hard to keep things together who don't want to become wards of the State or to rely entirely upon the Government still need some form of support.

I hope this hearing will result in a new form of health care, so that if my husband's condition worsens, we will not have the terrible worry of entering the ranks of the poor and going on Medicaid.

Thank you.

Mr. **Pepper**. We want to commend you for your great bravery and for the struggle you wage and are continuing to wage to meet your family's problems.

You have emphasized in the statement that you have made about how important Social Security is to your family, the importance of the program.

Those who would weaken it or destroy it do not realize how many people are like you, to whom Social Security means almost the lifeblood that you have.

The other thing is I would like to tell you I am hoping that we can get the legislation through this year. Some of us are supporting legislation to set up 20 treatment and research centers in the United States for Alzheimer's disease.

Dr. Robert Butler, who is one of our distinguished witnesses here today, used to be head of the Institute on Aging of the United States Government. He was the first person I ever heard of say that Alzheimer's disease was a disease and not simply senility on the part of the elderly, an idea which was not readily accepted.

He is working toward finding the cause and the cure of that terrible disease and particularly to find a way to treat it.

As you said, it requires the full-time attention of someone to help the victim of the disease. So, you have very movingly delineated a problem that so many people are meeting, like you, all over the United States today, and what we intend to do is help people like you, and we thank you very much for your statement.

The next witness is Mrs. Natalie Hall.

Mrs. Hall, we are pleased to hear from you.

STATEMENT OF NATALIE HALL, ARLINGTON, VA

Mrs. HALL. Thank you, Mr. Chairman. I appreciate the opportunity to be with you today and to make a contribution to your efforts.

Up to now it has been a private tragedy, but I believe as the other witnesses have said this is also a public tragedy.

My name is Natalie Hall, and I am here to share with you the story of my in-laws, who are currently holding their own financially, despite long-term illness. To be honest with you, none of us dares look into the future, however.

Both my mother-in-law, who is 75, and my father-in-law, who is 78, are members of a health maintenance organization or HMO. The HMO has been extremely beneficial in treating my mother-in-law's depression. She has received considerable treatment for that illness on an outpatient basis, and when it became so severe that it required hospitalization, that was paid for too.

During one period when she was hospitalized for depression in the spring of 1984, my father-in-law left their home and came to stay with my husband, three children, and myself. Soon it became apparent something was drastically wrong with him. He began hallucinating. Although a noted academician, he was barely able to make coherent conversation. He was confused about the identity of family members. This was the beginning of his and our bout with Alzheimer's disease.

After 3 weeks, my mother-in-law left the hospital for their home and my father-in-law left our care and returned home. For 10 months, off and on, they supplemented their care with various home health services.

The HMO did not pay for these home visits; my husband and I picked up most of the cost. Both needed constant supervision; they were not very strong physically or mentally. Besides the custodial functions such as cooking, cleaning, and paying bills, they needed to have medications monitored and administered.

We thought about hiring round-the-clock care, but that would involve three people altogether: someone on the day shift, the night shift, and on the weekends. If you multiply the average $6 to $8 an hour the average home health care aid of this type charges by 24 and then by 7 days, you can wind up paying $1,300 a week for that kind of care.

We rejected that option on the basis of expense, and they did the best they could for a 10-month period, using mostly daytime assistance only. But eventually their needs expanded beyond the capabilities of that type of care.

At that time they entered an adult home in Frederick, MD which specializes in the care of Alzheimer's patients, and this, I must note, was very hard to find.

Even though this facility does not provide skilled medical care, it costs $3,000 a month for the two of them. They are paying for the home out of their personal savings and the income they receive from their pensions and rent from their condominium.

As I have said, my in-laws are both members of an HMO. The HMO covers preventive care, most acute medical problems, and some care for my mother-in-law's depression.

It will not pay for a long-term nursing home stay, which is the inevitable finale for my father-in-law. Alzheimer's disease is a fatal disease. Its duration differs from patient to patient, and cases have been known to last for 10 years or more.

But the outcome is always the same. Right now my father-in-law is all right physically. It is his cognitive functions that have failed. He is still very genteel and keeps up a facade of excellent manners. He is still most comfortable wearing a tie.

All I can think is: What a tragic waste of an extraordinary mind. Dr. Hall worked in academia both here and abroad. He served 15 years with the Agency for International Development. He was a brilliant man.

A physician recently informed us that Dr. Hall might continue in his current state for another 5 or 6 more years. But Alzheimer's is a disease with irregular progress. He may find himself becoming extremely irascible. He has bursts of that now and then. Or he could become incontinent or in need of more specialized care than the home in Frederick can provide. He is a large man. If he became unruly, they would have to ask him to leave.

At that point when either of my in-laws need more skilled care, the only option I can think of is a nursing home. Then they would find themselves really financially strapped. Currently, they are living off his pension and rental income, and there is a delicate balance between their income and expenses. That balance could easily be destroyed.

There is another point I would like to make. My mother-in-law and father-in-law did everything they could to provide well for their retirement years. They now have the resources to live in a nice place. They saw their parents enter retirement age during the depression with very little savings, and they dutifully took care of them then.

But they wanted something different in their later years. They hoped to be self-sufficient. I am sure neither wanted their savings spent on a retirement home or a nursing home. As my mother-in-law said,"I just never thought I would get this sick."

And even if you do anticipate the possibility of ill health, I think most elderly people assume that their retirement savings will be adequate. But I have learned that, at least in our family's situation, this is not the case.

My husband and I became their legal guardians last April, when it became obvious they were not fit to govern their own affairs. It now falls to us to determine what living arrangement will be best for them.

Their adult residence costs $36,000 per year. If their health worsens, they will go to a nursing home, which in the metropolitan area here averages $20,000 to $30,000 per person annually. And I cannot begin to think where we would get that kind of money.

I have also noticed that at every civic gathering or party or church function, that someone has a parent or relative with Alzheimer's disease. The relatives are almost always having trouble dealing with it financially, and almost all of them have a very difficult time dealing with it emotionally.

We are able to make it for now because my parents had the foresight to put away some savings. But we are in a precarious position. When my father-in-law has to go to a nursing home, and I do not say "if", and also if my mother-in-law has to go, and given their ages and physical conditions is very likely, we would then be starting down the long road to using all of their lifetime savings. And I know they would have preferred those to go to the grandchildren.

I am pleased that the subcommittee is looking into this matter, and I sincerely hope that somehow we can change our health care system. My parents, my parents-in-law, my husband, and I certainly would have been glad to have the option to purchase some kind of insurance so that maybe perhaps through State, Federal, or private support the medical needs of our seniors and the people of all ages can be met.

Thank you.

Mr. **Pepper**. Thank you very much, Mrs. Hall.

I have heard tremendous statements being made by the last four witnesses, and all of them appear to me to be far above the average in a good portion of having assets.

One gentleman spoke about spending $100,000 in 2 years, and you spoke about yours and Mrs. De Croce and others. You were able to work; you had a job, the pay was pretty good.

What about the even poorer people? You are struggling, and you are good, middle-class Americans, people that have income, people that have homes.

Yet you told us the tragic experience you have and the bleak future, I regret to say, that even you face. What about other people in the country who are not as well off as you are? Imagine what they have to combat, what they have to struggle with.

So, I cannot understand a Government that could not have compassion for people like that, and that is why we are having this hearing today.

So, thank you very much, Mrs. Hall, for your own valuable information.

Our last member of this panel is Mr. John Burns, a postal inspector from Boston.

Mr. Burns, we are pleased to have you.

STATEMENT OF JOHN BURNS, POSTAL INSPECTOR, U.S. POSTAL INSPECTION SERVICE, BOSTON, MA

Mr. BURNS. My name is John Burns, and I am a postal inspector for the U.S. Postal Service in Boston, MA.

Each year literally thousands of unsuspecting Americans are defrauded by those who use the U.S. mails to perpetrate their crimes. Unfortunately, a disproportionate number of those victimized are elderly, and what better group to target?

The swindlers and con artists are well aware that: one, senior citizens as a group are known to pay their bills and pay them on time; that senior citizens are less likely to protest and file formal complaints than the population as a whole; and, three, senior citizens are more likely to use the mails for various purchases because of reduced mobility and lack of access to motor vehicles.

Today, however, I want to speak to you about a hideous type of mail fraud aimed at the elderly—the insurance scam. Certain unscrupulous insurance agents prey on older Americans' fears by selling, through a campaign of fear, worthless health policies.

The victim is reminded of the high cost of medical care and how a serious illness could quickly wipe out their life savings, and that he or she would become a burden to the children.

Some persons are sold multiple policies which provide duplicate coverage. In one instance, the victim of a case I investigated was an 86-year-old woman who had purchased a shoebox full of Medigap policies, policies which supplement Medicare. She paid over $45,000 in premiums over a 3-year period.

During that time she filed one claim, which was denied by the insurance company.

Another victim, 88 years of age, had paid thousands of dollars in premiums. She filed a claim for $400, for which she received a check from the insurance company for only $5.20.

Seniors identified as marks or soft touches are often subject to a technique called twisting by greedy salesmen. A salesman's commission for the first year a policy is written is very large, in some instances as high as 80 percent of the premium. The commission diminishes thereafter.

The unethical salesman proceeds to twist the client from one company and from one policy to another in order to obtain the high first-year commission. Another negative side for the customer is that many new policies require waiting periods before the coverage takes effect, and thus no protection is provided the unsuspecting insured.

During the past 8 years, I have investigated numerous types of insurance fraud cases directed against the elderly. I would like to be able to tell you that there has been a decrease in the fraudulent activities by those who use the U.S. mails. Unfortunately, based on numerous complaints that are continually received in our office, I know this is not the case.

Swindlers, acting out of greed, have found fertile soil to cultivate in the senior community. Their actions, limited only by the creativity of their devious minds, continue to be a nuisance to law enforcement and pose a threat to financial security of the elderly.

Our agency, the Postal Inspection Service, is attempting to take preventive measures against such crimes. A major portion of our Consumer Protection Program is directed toward educating the senior citizens of this country about potential mail fraud schemes.

Presentations are routinely made to various senior organizations. Informative pamphlets and other literature are also available. In addition, whenever fraudulent schemes are identified, we will continue to vigorously investigate these criminal activities in violation to the mail fraud statute and present them to the U.S. attorney for prosecution.

I am accompanied today by Mr. X, a former insurance broker, who spent 1 year in prison after being convicted of selling bogus insurance to the elderly. He will detail for you his firsthand experience in preying on the fears seniors have in meeting their health care costs.

Thank you.

Mr. **Pepper**. Thank you very much, Mr. Burns. I would like to comment on that after we hear from Mr. X. Is he available?

Not only do these fraudulent agencies sell spurious policies, sometimes policies no good to these victims who are generally the elderly, but they sometimes get them to cancel good policies that they have.

Now then, we are pleased to hear from Mr. X.

STATEMENT OF MR. X, FORMER INSURANCE SALESMAN, MASSACHUSETTS

Mr. X. Good morning. My name is Mr. X, and during the later 1970's and the early 1980's I sold insurance in the New England area. Although I wish to retain my anonymity, I am hopeful my testimony today will help the subcommittee and senior citizens in their search for health security. I would like to give you a brief summary of my background.

For 6 of the years that I sold insurance, I concentrated on various types of health insurance plans tailored to the elderly. I made sales while representing over a dozen different companies.

Ultimately I was arrested for mail fraud because of misrepresentations that I made to unsuspecting senior citizens and served 1 year in Federal prison.

Since then I have cooperated with Federal postal inspectors in the investigation of six other insurance agents about whom I had knowledge of illegal activities.

I am here today to describe my experience in preying on the fears of seniors with regard to health insurance. I hope something can be done to curb such practices, since I suspect they still exist today. Having spent 6 years in this particular market, I feel I have special knowledge of the practices and techniques used by salesmen.

A majority of our customers were senior citizens who lived alone. By the very nature of their ages, health care coverage was very important to them. Whether expressed or not, there is a real fear by seniors of losing their homes and assets and becoming a burden to their children. These fears make them very vulnerable to unscrupulous sales tactics. Among the methods I and other salesmen employed were the following:

No. 1 is "overloading." This includes the sale of multiple and duplicate health insurance coverage with no respect to the existing insurance portfolio of the customers. On occasion we would find it necessary to "clean house," and that is to physically remove policies from the premises due to the volume.

No. 2 is "twisting." The health insurance policies we sold contained preexisting condition clauses which would prevent payment of a claim for an illness or a condition which existed at the time the policy was sold. By changing or twisting a customer from one policy to another, my commission on the sale would be as high as 80 percent, as opposed to 10 or 5 percent for renewal. Side effects for the victim are that the customer is now a year older and must pay a higher premium and may not be covered for months or years because of the waiting periods.

No. 3 is "Soft touch" or "mark." Once a senior was identified as an "easy sell," I would pass along the names of clients to other salesmen to begin calling on him or her. We would then split commissions on subsequent sales.

No. 4 is falsification of applications. These include failing to list health histories, falsifying dates of births, failing to list other insurance coverage, overcharging for premiums, and forging signatures.

Prospective leads were routinely supplied by various home offices. These include responses to mail-order solicitations and other circularizations. These leads, used as door openers, would ultimately develop "marks." One such mark was a 90-year-old woman who suffered from Alzheimer's disease. I know for a fact she was visited by eight different agents on a biweekly basis for over a number of years. All of the aforementioned techniques were employed against her. Policies were "twisted" and falsifications were made on applications. During a 5-year period, over $35,000 in premium was collected and no claims were made. Furthermore, due to the "twisting," she was never actually covered. Periodically agents would drive her to the bank to withdraw from savings to pay for premiums when she did not have adequate funds in her checking account.

Frequently, agents would set a dollar amount in commissions for the day they would like to make before quitting or pursuing other leisure time activities. Using known "marks," $1,000 could be made in as little as 1 hour.

One such popular victim was a 75-year-old retired school teacher living alone, who was sold useless coverage by 10 different agents. She was especially fearful of being confined to a nursing home and was always willing to do anything which promised some sort of health or nursing home coverage. This information was passed along to the next agent at the time she was labeled as an"easy touch." I know of no insurance coverage which provides adequate nursing home coverage. Most policies pay these benefits only under very specific circumstances while providing "skilled nursing care" and all other claims denied.

During my years selling to the elderly there was only one small period that I could remember when our activities were curtailed.

That was in the late seventies when one of the major networks broadcast an investigative report on the health insurance industry as it pertained to the elderly. For about 1 month things were very slow. I know of agents who actually quit because of this. However, the results of the investigation were quickly forgotten and a favorable sales climate resumed.

As for today, I do not believe there is a more opportune time for selling health insurance to the elderly. If I were licensed to sell insurance today, I estimate that I could double or triple my earnings of just a few years ago. There is presently an advertising campaign which has actor Harry Morgan as its spokesman. I do not even know the name of the insurance company he represents, but I would love to have the leads developed as a result of his emotional appeal. It certainly preys on the fears of the elderly. If I could work for this company, I would be willing to work for only 50 percent of my commissions.

In my opinion, the same situation exists today as it did a few years ago when I sold insurance. Companies, through misleading advertising and salesmen utilizing unscrupulous sales techniques, are preying on the fears and vulnerability of the elderly. As long as there is a window of liability, based on serious illness not covered by Medicare, these practices will flourish.

Thank you.

Mr. **Pepper**. Mr. X, you have given us a vivid example of man's inhumanity to man. We have had a lot of experience in seeing not only many agents but also many insurance companies do the same in order to wring money out of relatively helpless people such as these elderly victims are.

I remember one instance. The insurance companies usually get attractive young men, gracious, good manners, handsome appearance. I remember one case where such a young man stopped by an elderly lady's room in a hospital, having learned that she had some money, and he said, "Mrs. Jones, I just happened to be coming through the hospital today, and I hear so many people speak so warmly of you, what a wonderful lady you are. I just wanted to come by and meet you."

"That's right kindly of you," the lady would say, and he would chat with her a little bit and say, "Thank you very much. I am very happy to meet you," and the next time he came by he would come back again and say, "You know, Mrs. Jones, I have been thinking about you. You are such a wonderful lady, and I was just wondering if there was anything I could do for you. I would certainly like to help you if I could. Do you have any cares or concerns about your health or future, taking care of maybe catastrophic expenses you might incur?"

And she would say, "Oh, yes, of course I do. I constantly worry about that."

"Well, it just happens I represent a wonderful insurance company," and he would start. That is the way he would introduce himself into the confidence of such an unfortunate lady. The result was that he sold not only a number of worthless policies to her for high sums of money, but also induced her to cancel some good policies that she had.

That is a common thing. We had a number of investigations about it, and in one case they sued us. It is now in court. But in order to let the public know exactly the tactics that some of these unscrupulous insurance companies use, we arranged that a TV company let us put a TV camera behind the screen, and we sent the videotape—we actually videotaped the actual sales pitch that this agent was making to one of our people. It was an elderly lady.

But he thought it was a good customer, and he was pouring out the usual sort of stuff that he gave to those elderly ladies, and of course they were very unhappy about it. They said it violated their privacy. So, they sued us about it.

By the way, we hope we did a little bit to publicize, as you helped us to do today, the tactics that are employed, all of which emphasize the need for us to develop some kind of a program that is legitimate, that is not dependent upon people who resort to that kind of tactic; namely, some sort of an insurance program that the Government can supervise, see that everybody gets a good deal under it, and where necessary the Government can give necessary aid to supplement what the individuals are able to contribute themselves.

That is what we are striving to accomplish, to find a way to do that.

Well, you have all been very helpful to us. The committee is very grateful to each one of you for coming here with the good statements that you have made.

We hope it may be a blessing not only to others but to yourselves.

Thank you very much.

Mr. **Pepper**. I have one of the outstanding men in America, the distinguished author of the book Why Survive?: Growing Old in America, and the eminent chairman of the Institute on Aging in the United States who has been a pioneer in many areas of the health field.

For example, it was he who was the first to say that Alzheimer's disease was a disease and not senility on the part of the elderly.

He was also the first in the medical profession of this country to put knowledge of the elderly into the curriculum of the medical students who were attending our leading medical schools.

So, today we are very much honored and pleased to have Dr. Robert Butler, Chairman of Geriatrics and Adult Development at Mount Sinai Medical Center in New York City, and Pulitzer Prize-winning author of the book Why Survive?: Growing Old in America.

Dr. Butler.

STATEMENT OF ROBERT BUTLER, M.D., CHAIR, GERIATRIC AND ADULT DEVELOPMENT, MT. SINAI MEDICAL CENTER, NEW YORK, NY, AND PULITZER PRIZE-WINNING AUTHOR OF "WHY SURVIVE? BEING OLD IN AMERICA"

Dr. **Butler**. I am very pleased to be here today, and I would like to submit for the record a proposal for the restructuring of Medicare which I actually presented just last Friday in Tokyo at a meeting of individuals from both the United States and Japan comparing our two societies. [See appendix.]

This was sponsored by the former Members of the United States Congress, the Japanese, and funded by the American Foundation, the Carnegie Corp.

My proposal reflects a 30-year career of thinking about aging. I would like to provide a few highlights.

I was pleased, as you were, over Secretary Bowen's interest and expression of openness and goodwill, but I must say that I want to deepen and broaden the meaning of catastrophy for older persons and their families; namely, long-term care illness, stroke, severe mobility problems, Alzheimer's disease, multi-infarc dementia, the conditions, some of which you have just heard about from the family members, conditions that require long-term care, institutionalization, and/or home care.

Long-term care need is the catastrophy. Acute hospital care, for example, even over 60 days, is acknowledged by the Secretary himself really as modest in percentage and absolute number.

Our Nation requires long-term care. You have listened to the anguish of families. We can no longer accept the pauperization, the humiliation that comes from spending down under Medicaid.

We do not have a long-term care policy in the United States. We do have a fragmented nonsystem. We have an inadequate home care system, although it is fast growing. We have extremely costly nursing home services.

All of this on this day has to be considered in the context of the diagnosis-related groups, where we are beginning to see strikingly and painfully a deterioration of care for older persons discharged, as it is said, sicker and quicker.

We do not have a severity index. We make our payments prospectively on the basis of a single diagnosis, even though the persons that we are concerned with today have multiple, complex diagnoses.

We cannot look at one phase of the continuum of health needs, acute care all by itself. We cannot introduce a modest Band-Aid either. We must really go to the roots and restructure Medicare.

That could well require and result from an initiative from both the private and the public sectors, although my belief is that we will ultimately depend upon a public basis, a Medicare Part C.

Let us get to the heart of it. Can we afford it? How would we do it? How would we restructure Medicare? And I say this speaking as a citizen of the richest nation in the world.

Can we afford to provide decent health security for our future selves and for present older persons?

My answer is clearly, yes. Many efficiencies in the health care system are required. It means more than just marketplace competition but regulation in the form of a counterpart to public utilities, social utilities.

We heard a good deal just now about the extent to which fraudulent activities can occur with regard to Medigap policies, but much less obvious types of disregulation and vulnerability of older people occurs every day in health care system.

We must bring to an end the open-ended drain on the Federal Treasury which has characterized Medicare from its beginning in 1965 by severe control of physicians, hospitals, and nursing homes.

It is interesting that hospitals are now making money on DRG's, and yet we have reached what probably is an almost unconscionable ceiling in the number of days older persons can be in hospitals of about 7.7 days.

We need well-trained providers in the health care system, and we need well-trained families. It is interesting that Medicare spent $2 million for graduate medical education last year and not one nickle went to the support of the development of geriatric medicine.

We need effective, managed care, involving an egalitarian, collaborative relationship between a team including the physician, the nurse, the social worker, the physical therapist, the nutrition counsellor, and the patient. This team must assess the function of the patients.

Patients are often effectively cured of a particular disease, that is, an infection, but their functional status may actually be worse at the end of their care as a result of a failure to provide a decent strong frame of rehabilitation.

We must build new methodologies, and these new methodologies of assessment have to frankly include triggering mechanisms that take into account realities.

For example, if the cost of care at home reached say 75 percent of prevailing nursing home costs, there should be clear, responsible reassessment with some penalties to the reassessment team for their failure to be effective in their analysis.

The team approach requires a team payment. That calls for a dramatic reform in reimbursement, moving us away from domination of fee for service and fee for procedures to a fee for comprehensive assessment and care. That will require a higher evolution in the health care system, but it is absolutely essential as we move along in the experience of longevity in the demographic revolution.

We must build new systems with a rational reorganization of financial sources of care available to us today. We do not even need as much new money in the system as one might think.

There are enormous resources in the Veterans Administration. There is a tax expenditure—which are tax-favored dollars—in the employer-provided health insurance, which at minimum estimate is something like $24 billion a year, making it the Government's second-largest health care system. And there are the private resources as well.

Another aspect at systems building and reorganization of the financial resources that bear upon decent long-term care is an investment in research. Even today the National Institute on Aging only accounts for 2 percent of the entire budget of the National Institutes of Health.

With some luck and with some sensible investment of funds in the understanding, and ultimately prevention and treatment of Alzheimer's disease, we could empty half of the nursing home beds of this country, half, simply by that hard work that could come just as we have been able to in the past, that comes about through the emptying of TB section sanitariums and the end of iron lungs for polio.

We can also look for new sources of funding. Home equity is one that is frequently discussed. Pension funds, rarely discussed, is another important use that could be made available for long-term care, and a marked enhancement of excise taxes on tobacco and alcohol.

Now, I know that often people say that prevention turns out to be expensive. It is controversial. And yet, health promotion and disease prevention seems clearly to be of great importance to the individual and the families.

We must build a kind of personal social ethic of health care and the support of family. We must also build neighborhood systems of voluntary care.

I had occasion to visit the People's Republic of China in coordination with the conference in Tokyo, Japan, which I mentioned. There we will be experiencing soon the result of the one-child-per-family policy so that the structure of the Chinese family and its care system for older people will be changed in many ways but not as dramatically as one might think because the Chinese have a very strong neighborhood structure.

I think some of our private-sector organizations, such as the American Red Cross, could play a vital role in developing our voluntary system, our neighborhood block in the care of older people.

I am less anxious about the utilization of long-term care IRA's or tax credits. They are distinctly middle class and benefit the middle class. And frankly, when it comes to the IRA's, we do not have the foggiest notion of what their value will be 20 or 30 years from now. It is a very weak peg upon which to devote the system compared to the strength, vitality and governmental backing of Social Security and Medicare.

Nor can we talk about the funding of a restructured Medicare without reference to the larger national context. Can we really afford this mindless Gramm-Rudman-Hollings approach which suggests no precision, no judgment, no choice, no wisdom, but a meat-ax approach to the larger issues of human care and security?

Second, what about those dropping oil prices? Who will benefit now? Remember that it wasn't so many years ago, 1973, that with the rise of OPEC-derived prices that we began to shred our safety net. Isn't it time to restitch it? Isn't it time to build some new programs?

And third, we all know that we have an extraordinarily inefficient and wasteful defense posture and Department which must require certainly the same degree of scrutiny as our health care system.

The special issues that have to be identified when thinking of a restructuring of Medicare are women and minorities. Women dramatically outlive men by 7.4 years at birth now, and minorities have had poor access to health care from the very start.

A few words only now about the program itself. It must be comprehensive. It must be community based. It must not include only an emphasis upon the traditional medical model.

In a sense geriatrics is a revolutionary call for a new organization of care, not so medicine, but a team. With new forms of payment, geriatrics must drive our analysis of the present health care system.

Medicare was built as though older people were young people. There were no checkups, no out-patient medication, no dental care, no hearing aids, no long-term care.

And yet, older people are not 25 years old. They do not simply suffer from acute hospitalized illnesses, although they do that. They usually present, at 75 to 80, with multiple, complex, interacute, and psychosocial as well as physical problems, and the most rapidly growing age group in all of the industrialized world, Japan and the United States, is the 85-plus age group, the group that is frail and very needful.

I recently went over some very disturbing data with Dr. T. Frank Williams of the National Institute on Aging from an East Boston survey that suggests some 38 percent of those over 85 have some degree of dementia, much higher than we thought.

The continuum or the spectrum of care must be in accordance with the constant, dynamic change in our own individual lives, acute care, then, chronic care, rehabilitation, hospice.

Now, what about home care? The controvery rages. Does it save money or cost money? Will new users come out of the woodwork? Well, they have not done so in Scandinavia, and they have not done so in the United Kingdom.

What is the insurable event? How do we decide upon precise criteria and means of assessment for home care?

I think it is double. Professional judgment says so.

To summarize, we need a valid approach to "catastrophic insurance," and it must go beyond acute illness. It requires a major basic restructuring of Medicare itself in its financing, in the development of a spectrum of services, in the education of the providers in geriatrics, and in the insistence upon a research strategy.

We should be responsive to the remarkable longevity revolution. In this century we have seen a gain in the average life expectancy of 25 years, absolutely extraordinary, nearly equal to what had been attained by humankind the preceding 5,000 years.

This calls for a celebration, a social imagination, a shift in mindset, and new policies. We really cannot allow ourselves to be taken in by the cost cutters and doom sayers who do not seem able to see solutions. If so, we might just as well cut out medical research, no more cancer research, no more heart disease research, because as a result of those activities we will increase that average life expectancy even more.

I submit that what is called old age is relative. In 1900, the average life expectancy was 47. Perhaps the Office of Management and Budget might have stopped Louis Pasteur from developing medical research and not have immunizations and antibodies because we are not going to be able to afford those older people that will come into being in the 1980's.

Well, we cannot afford that kind of limp thinking. We need a grand strategy and nothing else, a strategy that will bring together the private and public sectors with a strong Federal foundation in Medicare.

Since 1982 I have been calling for a long-term care commission to be congressionally chartered to have appointments made through both Presidential and congressional efforts with no representation from vested interests, no doctors, no insurance and nursing home executives, no hospital administrators.

All of them and all of us can be called on as necessary as expert consultants. But we need a commission that comprises seven or perhaps nine people from the larger world of education, finance, labor, industry, religion, church, and synagogue, voluntary-sector foundations.

I do not think we need tons more studies. We have been studying this topic ad nauseum. I personally have sat on task forces in both the Carter and Reagan administrations, and we have never gotten off the dime.

We need action. We need a tight timeframe. We need specific, concise recommendations to act upon.

People who are suffering today, such as we heard already this morning, cannot wait, so let's move and clearly let's move before 2020 when the baby boomers reach golden time. The first one just turned 40 on January 1. They are ready to become, I think, more and more sensitive to the politics of aging and the realities of aging as they see their parents and grandparents experience the type of lonely suffering which should be unnecessary in such a great and wonderous nation as ours.

Thank you.

Mr. PEPPER. Thank you, Dr. Butler, for that magnificant statement. You have covered all aspects of the matter theoretically and in practical regard, and we are going to ask you if you will cooperate with us in trying to implement some of the very things you have proposed in your statement.

Now, I would like to call as our last witness the Honorable Jack Ossofsky, the executive director of the National Council on the Aging, representing the Leadership Council of Aging Organizations in Washington, a long-time warrior in this great cause and one of our great advocates.

We are delighted to have you here today.

STATEMENT OF JACK OSSOFSKY, EXECUTIVE DIRECTOR, NATIONAL COUNCIL ON THE AGING, REPRESENTING THE LEADERSHIP COUNCIL OF AGING ORGANIZATIONS, WASHINGTON, DC

Mr. OSSOFSKY. Thank you, Mr. Chairman. As you know, I am the executive director of the National Council on the Aging. I am here today, however, representing Jacob Clayman, who is the current chair of the Leadership Council of Aging Organizations, and I am accompanied by Janet Myder of the National Council of Senior Citizens who worked with us in the development of testimony on behalf of the 30 organizations that make up the Leadership Council.

May I at the outset suggest or ask, Mr. Chairman, that our testimony become part of the record. I will be reading from parts of it and making some additional comments.

Mr. PEPPER. Without objection it will be so ordered.

Mr. OSSOFSKY. We had hoped, of course, this morning, as probably you had, to have heard some more specifics from the Secretary. I would hope that his openness in his morning remarks is indeed a reflection of his and the Administration's intention to deal with all aspects of catastrophic care needs and that we will all have an opportunity to shape that program, which it would appear, at least as of this morning, has not been changed yet. I would hope that that is the case anyway.

It struck me as strange, however, to hear from a Secretary a statement that what was being intended to produce was something cost neutral for the Federal Government. All of our experience in the last 5 years has taught us that that is a new catchphrase of this day. Cost neutral for the Federal Government means heavy burdens on the backs of older persons and their families.

I would hope what comes out of the new study is not that kind of cost neutrality in the lives of older persons.

Budget cuts, increases in premiums, increased deductibles cannot by any stretch of the imagination make the Medicare system more efficient. What it can do is continue to impoverish older Americans. I would hope that the system that we are finally presented by the Administration indeed offers us more than what we have had thus far.

In our testimony, Mr. Chairman, we present a number of questions which we ask the committee to use in judging any plan that comes before it regardless of the source. We have indeed as a leadership council been concerned with the effect of Federal policy on individual older persons and those who seek to serve them. And, of course, the role of the Government and private sectors in the area of catastrophic health insurance is one of great concern to us and our constituency.

In spite of the existence of Medicare/Medicaid, private insurance easing the elderlies' burden for out-of-pocket medical and related expenses is an increasingly difficult problem, the cost of services not covered by Medicare and the program's mandated cost-sharing levels, for example, continue to be a major concern to us.

Indeed, we would hope that as we look at the impact of health costs on older persons we do not overlook the existing agenda, the incompleted agenda of out-of-hospital drug costs, eyeglasses, preventive health care, dental care, and the long litany which has been pushed aside in the last few years as we seek to maintain what was achieved over 50 years of progress on behalf of older persons.

Of course the growing issue, as this hearing seeks to pay attention to in particular, is the disease which elderly people and their families face in trying to attain and pay for long-term chronic care services, particularly those that are community based. We have testified many times on behalf of the Leadership Council and our individual member organizations about the high cost of nursing home and chronic care, eye care, prescription drugs, and the level of deductibles, copayments, and the excessive fees of physicians who do not accept assignment.

We have expressed alarm at the fact that the proportion of income of elderly persons now spent on health care just about equals that of pre-Medicare days.

We have come before this committee and others voicing our concern that Medicare and private insurance are of still little help to Alzheimer's disease victims or their families, and we heard that further documented in the moving testimony that was given this morning.

Medicaid does not help all the low income of the aged. Nearly 6 million people of the age of 65 are either in or near poverty. Only 3½ million are Medicaid recipients. Many become Medicaid recipients only by first impoverishing themselves, usually by paing for nursing home care.

These long problems have been know to us for some time.

Mr. PEPPER. May I interrupt you for a minute. I have to take a call.

We will take a 5-minute recess.

Mr. OSSOFSKY. Thank you, Mr, Chairman.

I was in the process of reminding us that many become eligible for Medicaid coverage only after they have impoverished themselves and often as a result of nursing home stays.

These ongoing problems have not yet been solved, and indeed new ones have been added, changes in the Medicare laws. The prospect of deep cuts in Medicare funding due to the new budget that the President has submitted have and will continue to increase the elderlies' already high out-of-pocket medical expenses.

I am reminded of a shell game on the streets of Times Square where one has to look to see what the reality is. Is this administration really seeking to improve the quality and extent of health care coverage for older persons or is it really using that kind of statement to cover what it is doing to undermine even the current level of inadequate programs?

Every time we hear of a new improvement, we seem to be caught up in some new catch-65, and every bit of rhetoric is not substantiated by the actions of the administration in further cutting benefits.

For example, the highly touted prospective payment system is credited with decreasing the length of stay and saving the hospital insurance costs by a considerable amount of money. However, the beneficiaries are being penalized by the prospective payment apparent success because the deductible is still based on average cost per day, which is increasing as the length of stay declines.

That success has resulted in the deductible jumping 23 percent from $400 to $492 between 1985 and 1986 for each admission to the hospital. A strange way of measuring success from the perspective of older beneficiaries.

But the prospective payment system is creating an additional and financial care-giving burden. Hospitalized Medicare patients are being discharged in greater need of post-hospital care than ever before.

Social agencies that are members of the National Council on the Aging have reported to us of instance after instance of early discharge people being put on the roster for home-delivered meals, home health care, only to have to be rushed back into the hospital because they were discharged much too early.

Too many elderly persons and their families are discovering new and substantial gaps in coverage, the postacute care gap. Elderly individuals may need skilled care more often than intermittently but not 24 hours a day. They may need services unavailable in that community. They may need a level of care exceeding that of the hospital or physician.

Families and spouses report to us that they struggle to fill these gaps but do so at great cost to their financial and emotional well-being and health status.

The result is frequently impoverishment of surviving spouses, 75 percent of whom are aged women.

These evolving problems, Mr. Chairman, and the ever present need to keep up with rising medical expenses represent an increasing financial burden for the elderly population. Obtaining and indeed designing insurance to match the real needs of this high-risk group is a growing difficulty.

Mr. Chairman, I heard earlier some references to greater work with the private sector. We encourage that, but, as you well know, there are only a small number of private insurance companies that offer any kind of long-term care. Those premiums are high. The coverage is normally only for institutional care, and whatever is evolved from the private sector cannot ever become useful for this generation of older persons. We must look to the Federal Government's initiative and responsibility to take up this burden, indeed until they have fallen from which the private sector might be able to build higher. But we cannot depend upon the private sector with its purpose and motivation, perfectly valid in our society, to make a profit on the continuing illness and frailty of the growing numbers of older persons.

It is our responsibility to protect one another through the Federal Establishment, and we need to use the Federal Establishment and insist that it take the initiatives to give us the new benefits and protections that we need.

We are, therefore, pleased that the Congress, this committee, and the administration is beginning to move more vigorously in the design of a program, and we commend Secretary Bowen for recognizing the need to help the aged with high medical expenses, but we continue to raise the question of the definition of catastrophic coverage. Everybody agrees that there is need for such coverage. But what do we mean by it?

If we were to ask the President, Secretary Bowen, the Congress, a disabled individual, a retiree, a worker, an older woman living alone, or a person caring for an acutely or chronically ill relative, we would have a wide variation of definitions.

Probably for the bulk of persons catastrophic health insurance probably means coverage for an episode of acute illness or injury which requires lengthy hospitalization, expensive treatment, or rehabilitation, return to normal activity and work being reasonable expectations.

This is probably the definition we would get from younger working people, the nondisabled population, but this definition does not match the needs of most older persons. To base a plan on this acute care model and call it catastrophic insurance for the elderly is highly deceptive. Such a plan would help pay limited expenses to a very few aged in need but while failing to meet the catastrophic costs for the majority.

If the plan that is ultimately brought forth is in any way a descendent of previous plans suggested by the administration the cost for those benefits for the very few would be borne by the overwhelming majority of older Medicare beneficiaries.

About one in four of Medicare's 28 million aged enrollees is hospitalized each year. An estimated 200,000 remain hospitalized beyond 60 days. While the numbers who end up being there over 90 days are in dispute, it is clear that somewhere under 1 percent, probably somewhere under one-tenth of 1 percent, perhaps 12,000 older persons in our country exhaust their lifetime credit. A small fraction use up more than the 90 days coverage that they might currently have, and they are the only ones who would benefit at all if the package that we are given today is a repackaging of what we have been given in the past.

It should be emphasized that our testimony describes the impact of various long-term stays in the hospital, including readmission during a benefit period as well as extensive stays after that. Readmission after the completion of the benefit period of course means for the individual and the family another initial payment of $492.

The leadership council believes that it is of growing significance for the committee and for older persons to examine the impact of the readmission history increasing as a result of the current diagnostic group system.

Since the hospital length of stay for aged Medicare beneficiaries has dramatically declined from 10 days in 1983 to 8.7 days in 1985, it may be assumed that the stays exceeding 60 days will, in the future, also decline. While this may be true for consecutive days of stay, a potentially serious problem is arising which may negate these changes and further burden beneficiaries, however.

Whether medically appropriate or premature, hospital discharge statistics show a recurring sooner than before the PPS system was implemented.

If post-hospital placement arrangements of followup care and services required are inactive, nonexistent, or overburdening to spouses and families who are unprepared or incapable of caring for acutely ill elders, the patient may need rehospitalization.

The unintended consequence of the prospective payment system will not only endanger the health of the Medicare beneificiary but will also expose her or him unnecessarily to this new copayment requirement if readmission pushes the patient beyond the 60-day full reimbursement period.

These hospital-related expenses can be devestating to Medicare beneficiaries. In spite of that, the majority of older people need catastrophic insurance not to insure against the cost of long hospital stays, potent as they are for small numbers, but against the uncovered expenses of nursing home care, community-based services, chronic illnesses requiring long-term care.

Alzheimer's disease victims, for example, may never require hospitalization for acute conditions. However, they and their families have current catastrophic expenses not covered by any insurance coverage.

A stroke victim once qualified for part A or B benefits may still need institutional care or chronic care at home. Yet, the cost of such care, while catastrophic, will not likely be covered by Medicare or private insurance.

Interestingly, another area of growing health expenses unrelated to hospital care is becoming more apparent with the advent of the DRG's: Peer Review Group Organization requirements and the objective of cost-effective health care delivery, and that is the use of part B covered services is increasing.

Diagnostic and surgical procedures, which until recently were performed only in hospitals, are now routinely performed in outpatient settings. Avoidance of hospitalization, whether medically indicated or not, is increasing the demand for outpatient services.

Now, this may be good news for the Medicare beneficiary as unnecessary hospital admissions are reduced, but it also proves expensive to the beneficiary.

Part B coverage requires a copayment covering 20 percent of Medicare's reasonable charges. In addition, patients may pay additional fees when physicians do not accept assignment.

These are just a few examples of the elderly's potentially catastrophic expenses. Any insurance plan which purports to be catastrophic must be congruent with the elderly population's true need. If a plan is not congruent, it will neither be worth pursuing as Federal policy nor worth buying with public or private dollars.

Several catastrophic proposals are being discussed in and out of Congress. We believe that few would fully meet the need for protection against the types of catastrophic conditions we have outlined.

So-called catastrophic coverage related only to hospital stays would help too few Medicare beneficiaries. If such a plan is financed by short-stay hospital patients, it would increase their already high costs.

Other plans may be more congruent with the elderly's needs, but would be too expensive. The part B premium, already high enough for many, would nearly double under the President's budget plans. Adding yet another premium could make Medicare, part A and B, prohibitive.

Some plans would require excessively high out-of-pocket spending levels relative to income before catastrophic coverage is triggered. We are very much concerned about that notion, Mr. Chairman, because we hope that the benefits could be provided as a matter of right without an income factor being written into health coverage for older persons.

Still others would only parallel Medicare's acute care bias and would not count uncovered services for catastrophic eligibility.

We are concerned also that much more attention be given to coverage in the nonmedical model of community-based long-term care.

There are plans under discussion which show some promise in meeting the elderly's needs as well as those of people under age 65. These plans would implement catastrophic coverage not as a piecemeal, patch-up approach, but as part of an overall health system reform, and I would like to subscribe completely to Dr. Butler's call for a total reexamination of the health care system, not just Medicare, but particularly the health care system as it affects older persons.

Yet we know that if we do not deal with the health care needs of the whole population, the future aged as well as today's aged, we will scarcely be in a position to succeed on behalf of the aged.

Let no one perceive the aging organization's concern being only aimed at today's older persons. We continue to be as concerned and committed to adequate health care for the rest of the population which is yet to be old as we offer today's older persons.

Our concern, however, is that the longer we wait, the less likely it is that this generation of older people will survive long enough to benefit from the outcomes of endless studies and untold deliberations.

Our testimony, Mr. Chairman, lists a number of questions we urge you to use in evaluating the various plans that come before you. I will not take the time to read them all.

They ask, however, why the plan is being offered; what its motivation is; how the plan defines catastrophic expense; and what the plans benefits will be.

They include examining ways of meeting those early unmet needs from the origins of Medicare that are with us still.

We welcome the opportunity, Mr. Chairman, to express these concerns. We suggest that you look to see whether the program is affordable, not just in terms of its negative cash impact on the Federal Government, but its cash impact on older persons and their families.

Who bears the financial burden and are the benefits worth the price?

We believe that these various questions are urgent to ease the pressure of catastrophic expenses and must be answered positively and quickly.

Clearly, the number of the aged and their needs are continuing to mount. Today and tomorrow's aged and their families must be protected against the cost of catastrophic illness.

We look forward to working with you and the Members of Congress and the administration toward assuring the creation of protections still needed by America's older persons.

Thank you, Mr. Chairman.

[The prepared Statement of Mr. Ossofsky follows:]

PREPARED STATEMENT OF JACK OSSOFSKY

Mr. Chairman, I am Jack Ossofsky, Executive Director of the National Council on the Aging. Today I am representing the Leadership Council of Aging Organizations as its immediate past Chairman. I am making a statement for Jacob Clayman, the current Chairman, who is unable to attend this hearing.

The Leadership Council of Aging Organizations, LCAO, is a coalition of 30 national groups which represent or serve the aged. My written statement contains a list of member organizations. LCAO is concerned with the well-being of the nation's elderly, and therefore the effect of Federal policy on individual elderly people and those who endeavor to meet their health, financial and social needs. We are pleased to present our views on catastrophic health insurance because the personal cost of medical care is one of our major concerns.

In spite of the existence of Medicare, Medicaid and private insurance, easing the elderly's burden for out-of-pocket medical and related expenses is an increasingly difficult problem. The cost of services not covered by Medicare and the program's mandated cost-sharing levels, for example, have long been a concern to us. Another serious concern is the difficulties which elderly people and their families face in trying to obtain and pay for long-term and chronic care services, particularly those that are community based.

The LCAO and its member groups have testified before Congress many times about the high cost of nursing home and chronic care, prescription drugs and eye care, and the level of deductibles, co-payments and excessive fees of physicians who do not accept assignment. We have expressed alarm at the fact that the proportion of income the elderly now spend on health care nearly equals that of pre-Medicare days.

We have told Congress of our concern that Medicare and private insurance are of little help to Alzheimer's Disease victims or their families. We have reported that Medicaid does not help all low-income aged. Nearly six million people over the age of 65 live at or near poverty. Only three-and-one-half million are Medicaid recipients. Many of them become eligible only by first impoverishing themselves, usually by paying for nursing home care.

These problems have not been solved. New ones have been added. Changes in Medicare law and the prospect of deep cuts in Medicare funding, starting with the FY 1987 budget, have, and will continue, to increase the elderly's already high out-of-pocket medical expenses. For example, Medicare's hospital prospective payment system (PPS) is credited with decreasing the length of stay and saving the Hospital Insurance Trust Fund money. However, beneficiaries are being penalized by PPS' apparent "success" because the Part A deductible is still based on average cost per day which is increasing as length of stay declines. The deductible jumped by 23 percent from $400 to $492 between 1985 and 1986.

The prospective payment system is creating additional financial and family care-giving burdens. Hospitalized Medicare patients are being discharged in greater need of post-hospital care than ever before. Too many elderly persons and their families are discovering a new and substantial gap in coverage--the post-acute care gap: elderly individuals may need skilled care more often than intermittently, but not 24 hours per day; they may need services unavailable in their communities; or they may need a level of care exceeding that arranged by the hospital or physician. Families and spouses report that they struggle to fill these gaps. They do so at great cost to their financial and emotional well-being and health status. The result is frequently impoverishment of surviving spouses, 75 percent of whom are aged women.

Mr. Chairman, these evolving problems and the ever-present need to keep up with rising medical expenses represent an increasing financial burden for the elderly population. Obtaining, and indeed, designing insurance to match the needs of this high risk group is also a growing difficulty. It is one that is becoming more urgent as the number of people over age 65, with their attendant medical and long-term care needs, rapidly expands.

We are pleased that the Congress and the Administration have expressed interest in designing a plan to insure against catastrophic expenditures. We commend Secretary Bowen for recognizing the need to help the aged with high medical expenses and for expressing a desire to implement Federal policy measures to achieve this objective.

Now that there appears to be agreement on the need, the next major step toward protecting Medicare beneficiaries is to clarify and define the concept of "catastrophic coverage." It means many things to many people. If we were to ask the President, Secretary Bowen, the Congress, a disabled individual, a retiree, a worker, an older woman living alone, or a person caring for an acutely or chronically ill relative, we would hear a wide variety of definitions.

To most people, catastrophic health insurance probably means coverage for an episode of acute illness or injury which requires lengthy hospitalization and expensive treatment and/or rehabilitation. Return to normal activity and work are reasonable expectations. While this definition would most likely apply to the under 65, non-disabled population, it does not match the needs of most older people. To base a plan on this acute care model and call it "catastrophic insurance for the elderly" would be highly deceptive. Such a plan would help to pay limited expenses for a very few aged in need while failing to meet the catastrophic costs for the majority.

Approximately one in every four of Medicare's 28 million aged enrollees is hospitalized each year. Of these, an estimated 200,000 remain hospitalized beyond 60 days, the length of stay which triggers the daily co-payment requirement. Even fewer beneficiaries use Part A benefits beyond 90 days. Though small in number, these beneficiaries incur expenses under Medicare law that are indeed catastrophic. A daily co-payment of $123 is required of beneficiaries hospitalized 61-90 days, and $246 per day of those exceeding 90 days. A 70-day stay would cost $1,722: the $492 deductible plus $1,230 for ten daily co-payments. (Physician fees are additional.)

It should be emphasized here that the "70-day stay" in this example is not necessarily one of 70 consecutive days. A re-admission to the hospital within a "benefit period" is calculated together with the first stay toward the same 60-day period beyond which 100 percent coverage ceases. To illustrate, I cite a hypothetical case: After a 30-day hospital stay, an individual is discharged and remains at home for 17 days. He or she is then re-admitted for the same condition which necessitated the first hospitalization, and remains hospitalized for another 35 days. In this case, the patient, having already paid the $492 deductible during the first hospitalization, is not required to pay another deductible, but must pay $615 for five days worth of the $123 co-payment. The total out-of-pocket expenditure is $1,107. This total does not include additional expenses incurred for physician (Part B) services or those incidental to care at home. Thus, Medicare's cost sharing could consume two months' worth of Social Security benefits, or more, in a two-and-one-half month period.

The Medicare beneficiary fortunate enough not to need re-hospitalization for several months does not escape another financial burden. A second deductible of $492 is required. Though this patient may not experience a hospital stay requiring co-payments, he or she will have to pay $984 for the deductibles mandated by Medicare law.

My first example, hospital re-admission within a benefit period, is one that LCAO believes is of growing significance and warrants Congressional attention. Since the hospital length of stay for aged Medicare beneficiaries has dramatically declined from 10 days in 1983 to 8.7 days in

1985, it may be assumed that stays exceeding 60 days will also decline. While this may be true for consecutive days of stay, a potentially serious problem is arising which may negate such a change and further burden beneficiaries.

Whether medically appropriate or premature, hospital discharges, statistics show, are occurring sooner than before PPS was implemented. If post-hospital placement, arrangements for follow-up care, and services required are inadequate, nonexistent or overburdening to spouses and families who are unprepared to care for acutely ill elders, the patient may need re-hospitalization. This unintended consequence of prospective payment will not only endanger the health of a Medicare beneficiary, it can also expose him or her unnecessarily to the co-payment requirement if re-admission pushes the patient beyond the 60-day full reimbursement period.

These hospital related expenses can be devastating to Medicare beneficiaries. However, the majority of older people need catastrophic insurance not to insure against the cost of a long hospital stay, but against the uncovered expenses of nursing home care, community-based services and chronic illnesses requiring long-term care. Alzheimer's Disease victims, for example, may never require hospitalization for acute conditions. However, they or their families incur catastrophic expenses not covered by any insurance. A stroke victim who once qualified for Part A skilled benefits may still need institutional care or chronic care at home. Yet the cost of such care, while catastrophic, is not likely to be covered by Medicare or private insurance.

Another area of growing health expenses unrelated to hospital care is becoming more apparent with the advent of DRGs, Peer Review Organization requirements, and the objective of cost-effective health care delivery. The use of Part B covered services is increasing. Diagnostic and surgical procedures, which until recently were performed only in hospitals, are now routinely performed in outpatient settings. Avoidance of hospitalization, whether medically indicated or not, is increasing the demand for outpatient services. Although this trend may be good news for the Medicare beneficiary as unnecessary hospital admission is reduced, it may also be expensive. Part B coverage requires a co-payment covering 20 percent of Medicare's reasonable charge. In addition, patients pay additional fees when physicians do not accept assignment.

These are but a few examples of the elderly's potentially catastrophic expenses. Any insurance plan which purports to be "catastrophic" must be congruent with the elderly population's true need. If a plan is not congruent, it will neither be worth pursuing as Federal policy nor worth buying with public or private funds.

Several catastrophic proposals are being discussed in and out of Congress. We believe that few would fully meet the need for protection against catastrophic expenses. So-called catastrophic coverage related only to hospital stays would help too few Medicare beneficiaries. If such a plan is financed by short-stay hospital patients, it would increase their already high costs. Other plans may be more congruent with the elderly's needs, but would be too expensive. The Part B premium, already high enough for many, would nearly double under the President's budget plans. Adding another premium could be prohibitive. Some plans would require excessively high out-of-pocket spending levels relative to income before catastrophic coverage is triggered. Still others would only parallel Medicare's acute care bias and would not count uncovered services toward catastrophic eligibility.

Some plans show considerable promise toward meeting the elderly's need, as well as those of the under 65 population. These plans would implement catastrophic coverage not as a piecemeal, patch-up approach, but as a part of overall health system reform to benefit people of all ages and all ranges of acute or chronic need.

The Leadership Council of Aging Organizations asks Congress to examine very cautiously any proposal for "catastrophic" coverage. We urge you to ask many questions. Here are some suggestions:

Why is the plan being offered?

- Is it a part of comprehensive health system reform?
- Is it an interim measure to fill gaps before long-term reform is implemented?
- Is it another costly layer of insurance to compensate for failure to correct a faulty system?
- Is it a mechanism to increase general or trust fund revenue?

How does the plan define "catastrophic expense?"

- Is it limited to a particular category such as out-of-pocket expenses for hospital care under Part A?
- Does it include Medicare-covered and non-covered services?
- Does it apply to acute and chronic or long-term care expenses?

What are the plan's benefits?

- Will it limit, reduce or eliminate the Part A deductible?
- Will it cover Part A co-payments?
- Will it cover both Part A and B services?
- Will it cover acute, chronic and long-term care expenditures?
- Will it cover such expenses as those for prescription drugs, mental health services, nursing home care, alcohol treatment, or community-based care?
- Will it cap or otherwise limit out-of-pocket medical expenses? Which expenses will count toward triggering such a ceiling?

These are but a few areas of our concerns. In addition, we suggest questions such as: Is it affordable? Will it serve the population at risk? Who/what bears the financing burden? Are the benefits worth the price?

The Leadership Council of Aging Organizations believes that neither these questions nor the urgency to ease the pressure of catastrophic expenses should remain unanswered. Clearly the number of the aged and their needs are continuing to mount. Today's and tomorrow's aged and their families must be protected against the cost of catastrophic illness. We look forward to working with the Congress and the Administration toward assuring this protection.

LEADERSHIP COUNCIL OF AGING ORGANIZATIONS

American Association for International Aging
American Association of Homes for the Aging
American Association of Retired Persons
American Society on Aging
Asociacion Nacional Pro Personas Mayores
Association for Gerontology in Higher Education
Catholic Golden Age
Concerned Seniors for Better Government
The Gerontological Society of America
Gray Panthers
National Association of Area Agencies on Aging
National Association of Foster Grandparents Program Directors
National Association of Mature People
National Association of Meal Programs
National Association of Nutrition and Aging Services Programs
National Association of Older American Volunteer Program Directors
National Association of RSVP Directors, Inc.
National Association of Retired Federal Employees
National Association of Senior Companion Project Directors
National Association of State Units on Aging
National Caucus and Center on Black Aged, Inc.
National Council of Senior Citizens
National Council on the Aging, Inc.
National Indian Council on Aging, Inc.
National Interfaith Coalition on Aging
National Pacific/Asian Resource Center on Aging
Older Women's League
Retired Members Department/United Auto Workers
AFL-CIO Department of Occupational Safety, Health & Social Security
Villers Advocacy Associates

Mr. PEPPER. Thank you very much, Mr. Ossofsky, for your very able and comprehensive statement.

You two gentlemen have given the finest examination of the whole subject as I have ever heard, and you have stated so individually the compulsory nature of this matter that so many lives and so much health depends upon our getting something done and that done speedily.

It has been very disturbing to me to see the attitude of the administration generally, and I was very pleased to hear that the new Secretary of Health and Human Services advocates any kind of catastrophic insurance.

It is a step forward. Generally I regret to say that the administration has been regressive in its attitude. It has been adding to the costs that the elderly have to pay in producing the benefits generally received, and I am hoping that this is going to lead to a new approach and that Dr. Bowen is going to lead the administration toward trying to meet adequately the problems of the country of catastrophic costs from catastrophic illness.

I would like to read here for those that are present. I propose to introduce today with the signatures of, I hope, all of the many members of our committee, but I would like to offer for your consideration legislation I will introduce which will provide catastrophic coverage for individuals who incur long hospitalization, a policy which the administration supports as well as comprehensive coverage for the elderly requiring long-term care, catastrophic care outside the hospital, and at a cost we can all afford.

The bill to which I refer is to revise the legislation enacted in 1978, which called for the creation of a part C of Medicare.

All current and new beneficiaries could elect to participate in the new part C, and professional services provided under part C would include coverage of all copayments and deductibles under parts A and B of the program, eliminating the need for additional insurance to supplement Medicare.

In addition, the beneficiary will be eligible for skilled nursing facility services, home and community-based services for the chronically ill, intermediate care services, eye care, hearing care, dental care, and biannual preventive physician visits.

The new part C program would be paid for through existing funds from parts A and B and from beneficiaries' contributions.

Beneficiaries electing part C coverage would have to pay a monthly premium equal to 25 percent of the cost of the program. If in a given year the premium exceeds 20 percent of an individual's total income earned and unearned, their premium would be appropriately adjusted.

States will be allowed to buy in for Medicaid-eligible individuals.

To provide the service, the Health Care Financing Administration would begin a process of contracting with providers. I understand that Mr. Ioccaca saved $100 million by bidding for a lot of the providers' services.

I say to provide the services, the Health Care Financing Administration would begin a process of contracting with providers to offer the comprehensive package of benefits outlined above as well as standard covered services under parts A and B for a predetermined capitated rate per beneficiary.

This capitated rate would not exceed the average payment for covered services under parts A and B with additional contributions by the beneficiary of the total.

Medicare now pays out an average of $2,400 annually for Medicare enrollees in health maintenance organizations for services covered under parts A and B.

Therefore, the capitative payment could not exceed $3,200, with the beneficiary paying $800 annually.

This legislation, a new part C, recognizes and builds upon many of the trends already under way in the private sector. It builds upon the preferred-provider concept by stimulating private sector initiative to bring about reduced costs and expanding services for seniors.

While it is clear it will require skillful management and careful oversight by the Federal Government, its promise for the future of health care is significant and long overdue.

All sectors of society should benefit. Our bill will require no new expenditures. It provides catastrophic coverage currently available nowhere. It eliminates the need for supplemental health insurance, which is sold frequently, as we have heard today, confusing and rank, with potential abuse.

For doctors it will mean an increase in patient load, and for the insurance industry it will stimulate more innovative marketing options.

The main purpose of this legislation is to have something concrete to which we can look, upon which we can build a better system, a system nearly as perfect as we can make it.

I have given a great deal of thought to whether to start with the elderly and try to get a comprehensive coverage program for the elderly and then move to the rest of the population or to try it all at once.

I have come to the conclusion that at least for the time being it is best to try to make the coverage comprehensive for the elderly, hoping that we will derive information and lessons from that that will lead us to move on to what is our ultimate objective, comprehensive coverage for all the people of America.

As I have said this morning to Dr. Bowen, I hope the Lord will let me live to see the day when in my beloved America, by paying whatever he or she can and should, every man, woman, and child in this Nation will get the medical care that he or she should have which is available in the country.

I am glad to see this is a little bit of an opening of the door by the administration. Their program is grossly inadequate, but it is in the right direction.

Now, as I said to Dr. Bowen today, I hope you will go ahead and consider in your study, which is basically what he is proposing, a study, maybe to be carried out most of the year, include in your study comprehensive coverage for catastrophic illness at least among the elderly.

So, with the help of you two able gentlemen to perfect this bill that we have proposed and introduced today, I recognize its deficiencies and shortcomings, but we do want to proceed with it, and we will be grateful for your help to try to improve it to make it as near as to what you have delineated here today as you can.

Thank you very much gentlemen.

[Whereupon, at 12:30 p.m., the hearing was adjourned.]

APPENDIX

Questions submitted to Secretary Bowen by Chairman Claude Pepper

1. Q. Would you support a catastrophic insurance plan which would cover the costs associated with long-term care not currently provided by the Medicare program?

A. I support the development of a plan for the private financing of the long-term care needs of the elderly. Given the concern with Federal deficits and the need to insure that the Medicare program remain financially viable, I do not believe public funding of long-term care through the Medicare program is a feasible option.

2. Q. Please outline the steps you plan to undertake to complete the directive given you by President Reagan to develop a catastrophic health insurance proposal? How might the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging participate in this process?

A. The President directed the Department to report by year-end on "how the private sector and government can work together to address the problems of affordable insurance" for those whose life savings would otherwise be threatened when a catastrophic illness strikes.

o There are three major organizational components of the study.

1) An Executive Advisory Committee.
2) Three technical work groups.
3) A Private/Public Sector Advisory Committee.

Executive Advisory Committee

This committee is composed of most of the HHS senior staff, with the Chief of Staff as Chair. It is this group's responsibility to make recommendations and provide the final draft report to the Secretary.

The Technical Work Groups

To assist the Executive Committee, three technical work groups have been established representing the best resources of programs within the Department. One work group is responsible for the study of catastrophic illness in the general population; a second group focuses on acute catastrophic illness among Medicare beneficiaries; and the third group is studying private financing of long-term care.

Private/Public Sector Advisory Committee on Catastrophic Illness.

This committee is composed of some of the leading experts in health care. Its purpose is to solicit input from every interested party as it conducts public forum sessions in Washington, D.C. and across the country. The information provided by this group will be incorporated, by the Executive Advisory Committee, with the data and options developed by our three technical work groups.

The Chairman's offer of assistance is greatly appreciated. The Private-Public Sector Advisory Committee forums are scheduled for: May 14, in Dallas, Texas; June 20, in Washington, D.C.; July 30, in Chicago, Illinois; and July 31, in Oakland, California. Please let us know if you wish to participate in any of these sessions.

3. Q. How many Medicare beneficiaries had hospital stays greater than 60 days in length?

A. Our data indicate that in 1984 approximately 280,000 beneficiaries had hospital stays of longer than 60 days. When these beneficiaries are still in the same benefit period significant cost sharing requirements can begin.

4. Q. Would you consider raising the Health Insurance (HI) payroll tax as a method of financing a catastrophic health insurance plan under the Medicare program?

A. I believe that providing catastrophic protection under Medicare's hospital insurance provisions can be accomplished without resorting to any increase in the current HI payroll tax. Financing catastrophic protection through an increase in payroll taxes, though an obvious option, is one I believe we should avoid.

5. Q. Would you agree that for the Medicare population there are two categories of catastrophic health care costs, those associated with acute illnesses and those associated with chronic illnesses?

A. I agree that both acute and chronic illnesses can create catastrophic financial consequences for the Medicare population. The two categories of illness are not always mutually exclusive, e.g., a chronic illness can result in a series of acute hospital stays with accompanying outpatient medical services that can result in significant health care expenses.

Questions submitted to Secretary Bowen by Representative Oakar

1. Q. Dr. Bowen, how many seniors would actually use catastrophic coverage, if it were available? For hospitalization? For physician charges?

A. The exact answer to this question depends on one's definition catastrophic illness.

- In our opinion, catastrophic illness is best thought of as illness requiring out-of-pocket expenditures that would lead to financial ruin for the beneficiary or the beneficiary's family.
- Others have defined catastrophic illness as one of a number of specific diseases or conditions; as an illness requiring incurred medical expenses, or out-of-pocket medical expenses, above a specific dollar figure; or, as an illness requiring levels of expenditure that represent a certain percent of income.

No matter what the definition, it must be recognized that only a small number of patients will actually be affected, relative to the entire Medicare population (or the general population). However, the anxiety level of the whole population regarding catastrophic illness warrants appropriate action.

For hospitalization, our data indicate that catastrophic coverage would benefit:

- Approximately 12,800 Medicare beneficiaries who exhaust their reserve days for hospital coverage each year, and
- Approximately 280,000 beneficiaries who have hospital stays longer than 60 days when large cost-sharing requirements can begin.

The number of Medicare beneficiaries incurring catastrophic physician costs is more difficult to estimate than that for hospital expenses. However, preliminary figures on the Medicare population for 1983 reflect that in excess of 750,000 beneficiaries incurred Part B expenses of over $1,000 for deductibles and coinsurance alone. The preponderance of these expenses are related to physician services.

We are planning to include an assessment of the magnitude of physician and other health care service costs that are borne by Medicare beneficiaries as part of the Department's catastrophic study.

2. Q. Dr. Bowen, do you envision that a catastrophic option under Medicare would provide coverage for long-term care, including nursing home care and home-based services?

A. I believe that the preferred solution to the problem of financing the significant costs of long term care must be a private sector solution. In these times when we are addressing serious problems with the Federal deficit we are clearly reaching the limit of what government can do. Simply adding coverage to the Medicare program would only exacerbate our deficit problems and put the Medicare program itself in jeopardy. There is some private insurance available for long-term care needs, however, it is extremely limited. In 1984 only 1.6% of the total nursing home bill was paid through private insurance. However, forty percent of the bill was paid from private sources so money is available for addressing the problem. The solution would seem to be providing options for individuals to use some of their available income during their working years to prepare for any future needs for long term health care. Identifying the best options available is something that I expect will be accomplished through the catastrophic study, specifically that part of the study that will focus on private financing of long-term care for the elderly.

3. Q. Dr. Bowen, as you know, the hospital deductible under Part A of Medicare increased to almost $500 this year, not because of a tremendous increase in hospital charges, but because the average length of hospital stays under Medicare is declining. Unfortunately, all hospital copayments are based on this deductible, and most seniors in my district cannot afford to pay it. I am concerned that because of this large cost increase, good health care will become even more remote for many elderly.

Do you intend to look into ways to recompute the Medicare hospital deductible? If not, will the charges for your catastrophic hospitalization benefit be based on some other formula?

A. The increasing Part A deductible is something that I am very concerned about. First of all, let me mention that the formula at present is set by law. I have asked the Health Care Financing Administration to look into this matter and advise me of possible recommendations we would make to the Congress for modifying the current formula for computing the deductible to give consideration to the charges that have resulted from the significant decline in the average length of stay.

4. Q. Dr. Bowen, I have introduced legislation (H.R. 1401) which would offer a long-term care benefit under Medicare. My bill is based on some pilot programs, which are currently funded by the Robert Wood Johnson Foundation. These programs depend on case management and the availability of a range of health and social services which can be offered to prevent or delay the need for institutional care.

During the course of your one-year study, will you consider the success of these and other demonstrations which are currently operating and their applicability to the Medidare program?

A. Yes, we will be looking at such demonstration programs very carefully, along with a number of other similar initiatives funded by the Department, other foundations and tried in various cities and States.

Case management techniques which direct or "channel" the elderly client toward the formal and informal services most appropriate for that client are thought to have potential for reducing fragmentation and confusion for the elderly and their families. As you indicate, their potential is greatest when case management is coupled with the availability of a range of services in the community.

I would caution, however, that in evaluating the Department's own experience with channeling demonstrations, we found that programs had difficulty in differentiating individuals at greatest risk of institutionalization and that certain extraneous factors such as the supply of nursing home beds affect the ability of community care systems to achieve results. Overall, there was little clear evidence that such projects generate true cost savings, although there are significant administrative costs in operating such programs. Nevertheless, our study will be looking at what is known about this technique and assessing its strengths, its weaknesses and its potential for linkage with acute care systems.

5. Q. Dr. Bowen, the 1982 Advisory Commission Report recommended further study into the cost and effectiveness of Medicare coverage for preventive care and long-term care. Do you intend to direct such study, now that you are the Secretary, either during your one-year study or within another context?

A. The Department continues to be interested in the cost and cost-effectiveness of preventive care and long-term care, regardless of who pays. In the Department's current study of catastrophic health care costs, we will be assessing the feasibility of a wide range of mechanisms for financing long-term care costs. Although our interest is primarily in assisting the development of approaches which build on private sector resources, we will be assessing each in terms of its relationship to existing public sector funding mechanisms.

6. Q. Dr. Bowen, we've heard reports that some people in the Administration would prefer that a catastrophic benefit be financed with higher cost sharing for the current Medicare hospitalization benefit. Do you feel this is the best way to finance catastrophic coverage? Don't you think that raising hospital copayments might create a new financial "catastrophe" for the elderly?

A. The answer to the question of what is the best way to finance catastrophic protection for the Medicare beneficiary population is something I expect to determine based on the study currently underway. I have no predetermined answers. Clearly one appraoch is to finance catastrophic protection through higher front-end cost sharing, but the equity and reasonableness of that approach obviously depends on the magnitude of any increases, the financial impact it would have on beneficiaries, whether it would disadvantage lower income beneficiaries, and whether the cost would be equally shared. I share your concern that any proposal must be sensitive to out-of-pocket costs that beneficiaries must pay.

7. Q. Dr. Bowen, do you still agree with the recommendations made in the 1982 Advisory Commission Report? If not, what changes would suggest?

A. The recommendations made by the 1982 Advisory Council were, in my judgement reasonable and sound ones given the serious financial shortfalls then facing the Medicare trust funds. Some aspects of the Council's recommendations were influenced by a very serious financial crisis then facing the Medicare trust funds. Although the potential for trust fund deficits is still present, the urgency of the problem is not as severe as it was at the time of the Council's deliberations.

THE NEED FOR H.R. 4287: THE CATASTROPHIC HEALTH INSURANCE ACT OF 1986: MEDICARE PART C

HON. CLAUDE PEPPER

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday May 6, 1986

Mr. PEPPER. Mr. Speaker, you may know that on February 28, 1986, I introduced H.R. 4287, "Medicare Part C: The Catastophic Health Insurance Act of 1986," to provide for voluntary comprehensive and catastrophic health care coverage to our Nation's 31 million Medicare beneficiaries. I was most pleased to be joined by my distinguished colleagues the Honorable EDWARD ROYBAL, chairman of the House Select Committee on Aging, along with other members of the select committee, the Honorable MARILYN LLOYD, the Honorable BARNEY FRANK and the Honorable HARRY REID in introducing this important and timely measure.

For the last 4 years, the Subcommittee on Health and Long-Term Care, which I have the privilege to chair, has convened dozens of hearings and received thousands of pages of witness testimony in Washington, DC, and across the country regarding the need for a Federal response to ensure the solvency and to improve the benefit structure of our Medicare Program.

What is clear is that Medicare has been a Godsend to seniors and their families. While no one would suggest that this vital program be eliminated, all agree that major change is warranted. I am pleased to report that the Honorable Otis Bowen, the newly appointed Secretary of HHS made his first congressional appearance before my subcommittee on February 19, 1986—outlining the administration's recognition of growing dissatisfaction with Medicare shrinking benefit package. Unfortunately, many fear the administration may propose a minor reform at an increased cost to elders. I am hopeful this will not and need not be the case—and that the Congress will seize upon the growing bipartisan sentiment for comprehensive health care reform and bring about an improved Medicare Program with comprehensive benefits at no additional cost to the Government or consumer—simply by better management of our health care dollar.

I believe that H.R. 4287, "Medicare Part C: Catastrophic Health Insurance Act of 1986," can accomplish that noble objective.

WHAT WOULD THE NEW MEDICARE PART C OFFER SENIORS?

Participation in "Medicare part C" (hereinafter referred to as "part C") would be voluntary. Those eligible for part A of Medicare (hospital services) and part B of Medicare (doctor's services) would be eligible for enrollment under the new part C.

Part C would provide senior citizens with comprehensive catastrophic health care coverage currently unavailable under private or public insurance coverage. Services would include the elimination of current coinsurance and deductible requirements under parts A and B of Medicare. In addition, part C would provide: home and community-based services for the chronically ill; complete skilled nursing facility and intermediate care facility; eye care; hearing care, dental care, and biannual preventive physician visits.

HOW WOULD THESE SERVICES UNDER PART C, BE PROVIDED?

The new part "C" would be provided through an innovative approach to health care delivery and payment. Part C incorporates the best of the social health maintenance organization [SHMO] and preferred provider organization [PPO] models along with a strong Federal quality assurance system. "Eligible organizations" (doctor groups, hospitals, HMO's, PPO's, insurance companies and others) would be allowed to contract with Medicare to provide the comprehensive package of benefits outlined above as well as the standard covered services under parts A and B. To be eligible for a part C contract, organizations would have to meet stringent requirements related to access to care, quality of care, and financial viability.

In return for providing this full range of services, part C contract holders would receive a set capitated rate per beneficiary based on the cost of Medicare of providing care to the average beneficiary in a particular area (like that now paid to HMO's). In 1986, this capitated rate would be approximately $3,200 per beneficiary.

Direct health care providers (doctors, dentists, home health agencies . . .) would be paid set fees negotiated by the organization awarded the part C contract. This may be done either on a fee-for-service or capitated basis. Thus health care professionals would be guaranteed payment of set fees with the option of maintaining a fee-for-service payment system. These negotiated fees must be accepted as payment in full for services provided, eliminating all current Medicare copayments and deductibles for seniors participating in part C.

HOW WOULD SENIOR CITIZENS RECEIVE PART C SERVICES?

Any Medicare beneficiary eligible for part A and electing part B coverage will have the option of electing part C. Once the beneficiary has elected part C, he or she will select from the organizations in their area which hold part C contracts (as described above). The beneficiary then would receive all needed services from any direct care provider under contract with their selected organization. Once part "C" has been fully implemented, virtually all health care providers will have contracts with these organizations, and those seniors electing part C would be allowed full freedom of choice among doctors, hospitals, long-term care providers and others. There would be an "open enrollment" period annually at which time beneficiaries could change their selection of preferred providers.

HOW WOULD PART "C" BE FINANCED?

Part "C" would not be funded by new Federal expenditures, but by more sensible and efficient management of current payments from four major sources: (1) Current Medicare payments under parts A and B; (2) seniors' payments for private Medigap policies; (3) seniors' Medicare part B premiums; and, (4) the Federal share of Medicaid expenditures for long-term care for those States which choose to "buy in" to part "C".

Part "C" services would be tied to the services currently available under parts A and B of Medicare. Therefore, the first source of part C funding would be the amount Medicare pays now for services provided under parts A & B ($2,400 was spent on average in 1986 for each Medicare beneficiary).

Second, the vast majority of seniors now purchase private supplemental insurance to cover the costs of required Medicare copayments and deductibles. The average older American spends around $600 per year for a supplemental insurance policy. By electing the new part "C" of Medicare, seniors will eliminate the need to secure supplemental insurance. Seniors would instead remit $600, in the form of a monthly premium to the Federal Government to pay for part "C" coverage.

Third, Medicare beneficiaries now pay $15.50 a month in premiums for coverage under part B of Medicare (physicians' services). Part "C" would continue this premium which adjusts annually.

Medicare beneficiaries electing part "C" coverage would pay a total annual premium of around $800 for comprehensive health care—less than half of what they are now paying on average for health care annually. These premiums could not, however, exceed 20 percent of a beneficiary's annual gross income (earned and unearned). Payments to make up the difference in premium payments for these individuals for whom premiums would exceed 20 percent of gross income, would come from funds generated by delaying eligibility for part C covered services for 1 month after enrollment—a standard practice among private insurers.

Federal and State expenditures for nursing home care through the Medicaid Program total about $20 billion annually. States would be allowed to purchase part "C" coverge for Medicaid eligible beneficiaries at a rate equal to 90 percent of their projected average Medicaid payments for these individuals in the following year. Since State expenditures for elderly health care represent the largest and fastest growing segments of their Medicaid budgets, this should be a very attractive option for most States.

HOW WOULD SENIOR CITIZENS BE INVOLVED IN ASSURING HIGH QUALITY CARE?

H.R. 4287 gives seniors a strong role in reviewing the quality of care provided. It mandates the establishment of local part C community advisory and appeals councils. These councils would be strictly independent of those responsible for providing part C services and would be made up of senior citizens from the community as well as independent medical experts. Councils would hear all appeals directly and would have vested authority to reverse decisions made by the provider. Councils would also contribute to an annual Federal performance review to guarantee that contractees are providing high quality care to all part C beneficiaries.

HOW CAN WE BE SURE THAT PART C WOULD PAY FOR ITSELF—NOW AND IN THE FUTURE?

H.R. 4287 strictly prohibits new Federal payments to provide funding for the new Medicare part C—now and in the future. It prohibits payments for part C from exceeding a set percentage of the average costs for providing current part A and B services. It further specifies that the entirety of these additional funds must come from beneficiary contributions ($12 billion, approximately), funds generated by imposing the 1 month waiting period for part C benefits (estimated at about $2 billion), and State and Federal payments for long-term care provided to Medicaid eligible elderly in those States which choose to "buy in" to part C ($16 billion if all States "buy in").

There is a pressing need for comprehensive Medicare reform. H.R. 4287, "Medicare Part C: The Catastrophic Health Insurance Act of 1986," provides for this reform, joining the best of public and private sector ideas and initiatives. I would therefore strongly urge my colleagues to join me in support of this timely and most important legislation.

THE RESTRUCTURING OF MEDICARE

By Robert N. Butler, M.D.,

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INTRODUCTION

This essay embodies a geriatrics-driven critique of Medicare. This is a rarity.* The program generally is evaluated in terms of insurance and social insurance principles, procedures, objectives, and cost evaluations. These approaches are not to be disparaged but they are dangerously incomplete.

The absence of a geriatrics point of view produces lopsided instruments of health policy for America's aged population of 27 million persons, mostly women. While the total elderly population is growing, the very old group within it is growing faster. It is this group that has heavy needs for geriatric service. There were 10 million Americans aged 75 and older in 1980. Estimates are 13.7 million in 1990, 16.9 million in 2000, 18.9 million in 2010, 21.5 million in 2020, and 30 million in 2030. It would be a mistake to consider the majority to be seriously disabled; it would be equally mistaken to overlook the fact that morbidity rates rise with age.

The focus on Medicare's inadequacies in geriatric terms is not intended to divert attention from needs for broader changes in American health care. Some 30 to 35 million Americans are uninsured or under-insured for health care. It has been distressingly easy for children to be ignored. A sensitive health-care system, reflecting a sensitive society, should respond to all stages of life. From the professional health viewpoint, the life cycle as a whole is the appropriate subject of a health-care system. National health insurance (NHI), a logical response to these outlooks, was defeated during the Administration of President Harry Truman in the early 1950s.

Medicare was a fallback position for NHI advocates in the 1950s and 1960s. They hoped that once NHI for older people was established the next likely step would be NHI for children (or "Kiddy Care"). Although NHI was considered an idea whose time had come in the early 1970s, the opportunity was overtaken by economic conditions in general and the rapid inflation of Medicare costs within the inflating health-care system.

For issues related to life-cycle concerns and costs of the health-care system, the context for effective redress is some comprehensive approach — NHI or a national plan of health services. Failing that for the moment, reformers are left to improve the pieces of program and policy at hand, such as Medicare.

I expect that an outgrowth of a true system of geriatric care will be intensified concern for the preceding part of the life cycle. The geriatrics practitioner deals with an individual having problems rooted in earlier life. Research in geriatrics has utility for those interested in health promotion and disease prevention in children, teen-agers, and young adults. Geriatrics research also holds significance for population-wide policy, because old age may reveal the subtle and long-term contributions to disease and disability of occupational, environmental, psychosocial, nutritional and other conditions.

There are, of course, risks to the U.S. economy when the prices of goods and services incorporate costs of a system of care that is less effective and efficient than it should be in meeting the needs of an aging population. Without developing this point further, I simply want to suggest why, if not comprehensive reforms, at least the restructuring of Medicare is a topic of broad interest.

Health care for the elderly population is substantially different from health care of younger adults. For example, one distinguishing characteristic of old age is the likelihood of multiple, simultaneous crises or losses, and they may be superimposed on chronic illness and anxieties about incapacity and dying. Often remarkable, the capacities of an octogenarian to recover or compensate without assistance are compromised. These blows are in the form of disease, accident, bereavement, isolation, immobilization, problems in activities of daily living, hearing loss, and financial stress. In the form of age prejudice (ageism) reactions to the individual can impede recovery or survival. Such a framework, so different from that common in the younger adult, necessarily changes the work of professionals.

Geriatrics involves considerations of health and supportive social services across the entire spectrum of preventive, acute, chronic, and rehabilitative care. This breadth of attention requires the work of a team, not always to effect cure of a disease but to sustain as much of a desired lifestyle as the patient's capacities allow. The patient and family members and friends, if any are available, are part of the team along with professionals. By contrast, illness in the younger adult is usually a temporary departure from full functional capacity.

It is argued here that commercial insurance has not supported, and perhaps cannot support, the service requirements of the U.S. geriatric population. It is predominantly a low-income population, all the more so at the oldest ages. The very old do not form a profitable market under present circumstances. Policymakers would be imprudent to seek to answer the needs of the very old on the basis of what is insurable.

I view the overreliance on insurance policy at the sacrifice of health policy as a serious flaw in the evolution of Medicare and a danger to the frail elderly, notably in the omission of outreach, prevention, and long-term care services.

I contend that Americans already are paying for a geriatric system — but aren't getting it. Extravagance in payments for hospital and doctor services has been demonstrated; however, most of the "savings" are not being invested into comprehensive geriatric care.

There is enough in the $70 billion a year spent by Medicare, over $12 billion a year for the poor elderly through Medicaid, and in other federally aided health and social service programs to support much of a care system suited to the needs of the 10 million Americans over age 75. New kinds of service delivery, the use of allied health professionals, and the support and cultivation of the natural networks of informal support would enhance effectiveness and affordability of Medicare restructured.

The attempt here is to reconceive the program as a system of financed health and social supportive services, manpower training, research, and development activity.

A. Paradoxes of Progress

Unlike most other industrially advanced countries, the United States has no program of national health insurance. It has maintained health insurance in the private sector, with the overwhelming portion of the population covered through employment. The major exception, excluding noncontributory programs for veterans and for the poor, is a federal program called Medicare. This is a program primarily for persons aged 65 and above.

The reason for the exception to private coverage is that a retirement population cannot afford the premiums required to cover the actuarially determined expense risks of sickness. (1)

Medicare came into existence in 1965 as a national program because of the inability of private health insurance to serve this population. Nor could State welfare programs (medical assistance) or State-blessed private insurance pools handle the burden of this growing population of elders. These inadequacies meant that many older people — over 50% were then estimated to be in or near poverty — had no practical way of avoiding destitution because of expensive illness. Medicare represented a broader kind of social support necessary for resolving the problem: an earmarked payroll (for Part A), general revenues and beneficiary payments (Part B).

Even this was insufficient inreaching many elderly persons: medical assistance had to be contindued and improved. In the mid-1960s, more than half the elderly population was in or very near poverty. In 1983, medical assistance was necessary for the 14.1% of America's elderly who were in official poverty and an additional 10% who were close to it.

Health care for the poor is paid for under a program called Medicaid, a federal-state govenment program covering 3.5 million older persons. In 1965 when Medicare was enacted into law as part of the Social Security system, Medicaid also was enacted in another portion of the same legislation. This continued a division in the way the American federal system approached vulnerable populations: social insurance and welfare approaches characterized the original Social Security Act of 1935.

There is yet another distinction to be made between the two programs. Medicare is modeled after private health insurance for the employed. Its strongest protection is against the expenses of hospitalization for acute illness. Job-based insurance was designed for people of young and middle age when the main threats to financial security arose out of acute illness rather than chronic incapacity. Typically, the private insurers left chronic care expenses to government and philanthropy (such as mental illness and long-term physical disability which were taken care of in nursing homes and large public hospitals).

Similarly, private insurance limited its coverage of physician services to diagnosis and treatment of short-term illness. Whatever the value to public health might be of preventive medicine, mental health services, and long-term care, classic insurance principles seemed to dictate their exclusion from private arrangements. They were too hard to insure.

The political need for conservative votes to assure enactment of the liberal Medicare legislation confined the program to the conventions of private insurance. The insurance industry was mollified with a role as intermediaries. Organized medicine, to avoid the inclusion of physicians in a mandatory program (Part A), accepted coverage of their services in Part B.*

Nonetheless, Medicare did amplify some of the more daring aspects of private insurance, such as coverage of home-health services and the post-hospitalization nursing-home benefit. (In doing so, Medicare executors wrote national standards for the providers of these services.) Architects of Medicare avoided coverage of long--term care out of fear that the additional costs in an untried federal system might play into the hands of opponents. While there was cost and administrative experience with insurance for hospitalization, such experience was absent for "custodial care" in the nursing home. It also was argued that if heavy acute-care expenses were covered, people could afford lesser expenses.

The 1965 version of Medicare was considered a first step, not only for improved protection for the elderly but also for national health insurance. In the meantime, proponents said an improved medical assistance program (Medicaid) would serve as a back-up protection for those whose care expenses threatened or produced indigency.

While Medicare worked to preserve the independence and health of the acutely ill, it left chronic care substantially to Medicaid. Unfortunately, Medicaid is triggered after these patients lose their financial independence and even their functional independence, too. For example, by the time a sick spouse is eligible for nursing-home care under Medicaid, that person's problems have deepened and the well-being of the well spouse has been compromised. Fear of poverty, often for the first time in a life of independence, may become an overwhelming stress and a barrier to health-protective steps.

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* Actually, Medicare is not, strictly speaking, an insurance program; it is a prepayment program. An insurer takes a risk that the premium charged for the offered protections will be enough to cover expenses and provide a profit; if the guess as to premium adequacy is wrong, the insurer uses capital or borrows. For Medicare, the Congress taxes to meet expenses. No risk is taken in the conventional sense.

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The following figures indicate the roles now played by Medicare and Medicaid in care of the elderly: the United States in 1984 spent $4,200 per capita for the elderly population's personal health care, or $120 billion. Medicare paid almost half, other government programs paid $22 billion, private insurance paid $9 billion, and the elderly and families paid $30 billion out of pocket. Because Medicare covers only 45 percent of the total cost of their health care services, two of every three Medicare beneficiaries carry private "Medigap" policies, typically, paying the Medicare deductibles and copayments and some additions to hospital and post-hospital care. These policies have been called overprices for what they offer; anxious elderly purchasers mistakenly believe they add long-term care to their Medicare benefits through Medigap.

In view of its historical and political roots, it should be no surprise that Medicare virtually ignores preventive medicine, mental illness, dental care, and long-term care. Nor does it pay for outpatient drugs. By contrast, Medicaid — the federal-state program for the poor -- covers the Medicare-excluded benefits. The extent to which it does, however, differs among the 50 states and the District of Columbia. Eligibility and benefit structure vary within limits allowed the states for qualifying for federal subsidies. (2)

Among major problems in geriatrics is maintaining the frail elderly person at home rather than in an institution. Home care is one of the most difficult services for conventional insurance to cover. For the hospitalized patient, the "insurable event" is admission to the hospital. What is it for home care? Is its use more under control of the patient than the doctor? The issue is in doubt for the insurer, who must calculate odds on the use of services. For this reason, home care is most comfortably approached in conventional insurance as a post-hospital benefit. In Medicare, the benefit is hedged against "custodial care," the services needed to maintain the stabilized patient. Yet the physician in geriatrics knows that the stabilized patient may easily require acute care and hospitalization unless maintenance services are given. Such services may be as humdrum as help by a home attendant in getting out of bed, going to the toilet, getting dressed, preparing a meal and taking medications on time.

This is the "custodial" care Medicare statutorily excludes from payment.

American systems of social and private insurance have stumbled on this issue. The absence and fragmentation of services and their financing confront the patient in need of "custodial" care in the community. This chaos bedevils the practitioner, patient, and family. It eventually generates admissions to hospitals and nursing homes, and these costs bedevil Medicare and other third parties.

Family members, friends, and volunteers constitute the principal caregivers of the at-home elderly. This network of informal supports would collapse without professional services. Skilled geriatric practitioners work to sustain this network, but insurance is not geared to nurturing it. Many families exhaust themselves in attempts to keep the frail person at home. Respite care, counselling, training of the family on how to deal with problems, and provision for professional help in the home in crises would support families in avoiding institutionalization.

The foregoing analysis suggests the following paradoxes:

1. The Medicare program for the elderly does not cover major geriatric needs. It is not a true geriatric program.

2. If Medicare is non-geriatric, Medicaid is anti-geriatric. The Medicaid program for the poor contains the missing geriatric benefits needed for a comprehensive Medicare program. But Medicaid's heavy emphases on institutionalization and poverty status foster dependency. A major goal of geriatric practice to encourage and promote independent living to the greatest feasible extent.

3. Medicare grows in cost while shrinking as a shield against poverty due to sickness. Now, because of increases in cost-sharing, the elderly are shielding government against Medicare bankruptcy. Result: The program is being repealed, de facto. Beneficiaries are more and more exposed to medical indigency. (3,4) (The bulk of the growth of Medicare expenses is traceable to a variety of causes beyond the control of patients, such as uncontrolled doctor fees ordering of services, cost-plus reimbursement for hospital services, hyperinvestment in acute-care technology.)

4. As the Medicare shield shrinks, more people need expanded protection. The numbers of very old persons are growing dramatically; the number aged 75 and older, now about 10 million, will reach 21.5 million in 2020, and their proportion of all elderly persons will enlarge to 42 percent from 39. Both the rate of spending for care expenses and the rate of indigency rise with age. (In New York State, for example, 1 in 3 persons over age 80 age receive Medicaid benefits.) But both Medicare and Medicaid obstruct the development of an adequate infrastructure (manpower, service systems, and facilities) for geriatric care. Medicare retains an explicit proscription against "custodial care," and Medicaid funding is problematical. Both programs provides no secure flow of funding for community-based services, and there is virtually no private long-term care insurance. (5)

Thus it is that Medicare helps people to survive the acute illnesses, only to fall into poverty in very old age, while Medicaid helps people only after they have lost their financial independence.

Why has the United States lost so much of the forward thrust in developing protections against poverty in old age? Part of the answer of course is money. The economic surge of postwar America faltered in the early 1970s, as it did in many advanced countries. In the remarkable quarter century of growth in wealth and in population (including the baby boom of 1946-1964), the United States could afford to raise living standards for the elderly as living standards rose for the work force. It could also finance foreign aid, the Vietnam war, and the nuclear buildup. The inflation of the 1970s threatened living standards and provoked attacks on the programs whose taxes cut take-home pay. The later 1970s saw almost a complete loss of forward motion and even some retrenchment under a Democratic president, Jimmy Carter.

Amid predictions of Medicare bankruptcy, the Reagan Administration attempted to dismantle Medicare. But it had to alter course in the face of the program's popularity. The attack shifted to nibbling away at beneficiary protections and taking a strong, prescriptive approach to methods of paying doctors and hospitals. In 1983, a National Commission on Social Security Reform produced a consensus on safeguarding the nonMedicare aspects of the Social Security system. Medicare reform proposals were awaited from other quarters. Meanwhile, owing to legislative and administrative changes in Medicare's payment patterns, the date of the program's "bankruptcy" receded into the mid-1990s from the early 1990s.

The geriatrics-based criticism offered here is intended to remove serious inadequacies from a praiseworthy program whose accomplishment should be acknowledged. Where half the aged had no private health insurance 20 years ago, now virtually all have hospital and doctor coverage. They are in the mainstream of American medicine, not on its margins. To some extent because of improved access to care, mortality rates for the over-65 population have diminished in the 20 years since Medicare was enacted.

Yet it is hardly churlish in the face of Medicare's contribution to the elderly to note that American medicine has made no corresponding major shift to geriatrics. In 1977, an American Medical Association survey showed fewer than 700 of the Nation's 350,000 physicians claiming a practice focus in geriatrics. Only a few medical schools offered an elective in geriatrics and none had a mandatory course. In 1983, virtually nothing of the $1.8 billion Medicare paid hospitals in 1983 for costs related to medical education was earmarked for training in geriatrics. There is only one department of geriatrics in America's 127 medical schools, and that one was established only two years ago, about 18 years after Medicare's enactment. By this time, however, Medicare's payments for graduate medical education were considered fair game for cutbacks. Some members of Congress proposed preserving some of the money for the development of geriatrics training. This was entirely reasonable, a move indicating a view of the program as a service system supported by manpower training.

Overall, however, Medicare and medicine are out of alignment with population needs.

B. Adapting to the Demographic Revolution

The political/economic environment of the 1980s complicated the case -- fatally, some thought -- for expanding Medicare in the near-term. About the best that could be expected was to continue marking time with "demonstrations" of flexible use of Medicare money for long-term care. Some demonstrations have shown ways of adding long-term care to the conventional Medicare-benefit list without additional expense to the program.

These results, lin addition to the longer record of savings achievable through prepaid group practice, suggested that Medicare funding already was sufficient for major geriatric reforms -- if only policy barriers could be overcome. The barriers included (1) the proscription against custodial care, (2) extravagant methods of paying for hospital and doctor services, (3) resistance to trying new methods of delivering and financing services, (4) ignoring the demographic trends and the cost implications of added years of life.

The growing 75+ population brings with it a high morbidity load. ( ) Individuals who, in another era, might have died in their 40s, 50s, and 60s, are surviving into the 70s and 80s -- with partial disabilities. The kinds of services needed by the sick elderly are medical, nursing, and social services for the short-term and long-term.

The well elderly, also a growing subpopulation, are increasingly vulnerable to serious illness as they age. Their service needs lie in the direction of periodic monitoring and preventive care. Other vulnerabilities stem from financial depletion and the loss of supportive spouses and other cohort members.

The elderly and their families must be considered in the context of services, financing and other supports needed to function at home or in the community. To ignore social supportive services and the needs of the principal caretakers is to set the stage for enlarged institutional expense, including acute and custodial care.

The design of a sound system of geriatric care must take into account a variety of demographic characteristics. The problems of an aging population are, foremost, the problems of women. They constitute two-thirds of the elderly. Women tend to outlive their spouses, to live alone, and to command slender incomes. Not surprisingly, they are the majority occupants of nursing homes.

The kinds of services particularly needed by a geriatric population include adult day care, respite services, home attendants or homemakers, chore services (e.g., home repairs), transportation, sheltered or congregate housing (with meal service), hospice programs, and skilled, intermediate and other nursing-home services.

Because the goals of care for the very old focus on minimizing their characteristic vulnerabilities, personnel and facilities must be prepared differently from those directed at the needs of the younger adult. The training of medical, nursing, and social service professionals in geriatrics must relate to the multiple conditions old patients have. These do not occur in a well-spaced series, as often the case with younger adults, but simultaneously, with psychosocial and economic as well as medical ramificatons. The main objective often may not be cure of the disease, for that is not always possible. Rather it is to promote ability to function, to conserve as much of the patient's desired lifestyle and independence as possible.

Professionals must be aware that "disability" describes a relationship between the individual's physical and psychologic capacities to function and the social and physical environment. The home, community and employment environment may facilitate or obstruct the individual's ability to perform and maintain a lifestyle. These factors must be examined for health impact.

The professionals must be taught methods for assessing patient needs and resources and the preparation of a plan of care acceptable to patient and assisting others. The plan may require considerable effort in educating patients and assisting others on the nature of normal aging processes, the early signs of disease or dysfunction, when to contact professionals and what to do before this becomes necessary. It is essential to good geriatric care to incorporate health promotion and disease prevention in the plan of care. This is a tall order, and requires more skills than any single practitioner may provide. The multidimensional nature of geriatric assessment and care implies the use of a medical/nursing/social work team.

To do these things well and to continually improve the efficiency of services, professional education must be placed in the context of research -- health delivery research and basic biomedical and sociobehavioral research. The system of delivering services for the elderly must also be a system of research and education. One tool for this, the teaching hospital, has been joined by the teaching nursing home. To these should be added health maintenance organizations that do research and teach and home care agencies that do research and teach. In all these settings, practitioners must be trained for teamwork.

The significance for cost containment of research and education cannot be understated. All of us know how research into the nature of poliovirus led to a preventive measure that obviated the need for expensive treatments. This feat demonstrated that research was hardly an expendable item in modern society. Less dramatic but nonetheless important research findings and treatments are needed in an aging society to prevent functional losses from occurring initially, to prevent further losses due to complicating conditions, to rehabilitate, and to compensate for permanent losses. To the extent that individuals can be trained to help themselves and contribute to society, they preserve their autonomy and morale and they free formal and informal providers for other productive activities. This should be the spirit of the system of service/education/research, and service-payments patterns must contribute to this infrastructure.

Similarly, the service system's institutional environments must reflect sound geriatric principles, particularly to facilitate independance. Hospitals must be designed for geriatric patients: color schemes should help guide the cognitively-impaired patient to service areas, sound conditioning should minimize confusing background noise and facilitate speech comprehension, lighting should aid the cataract afflicted by minimizing glare, safety should be designed into furniture, floor coverings, and hallway layouts so as to protect patients with disorders of gait.

The Medicare program cannot be expected to cover the enormous gamut of societal adaptations required for the safety and care of the very old. Medicare's proper theatre of action should be health care and allied social supportive services. What I turn to now are steps to apply the foregoing principles.

C. Private or Public Solutions

In America, policymakers have to engage the question of whether the improvements in services for the elderly should be accomplished in the public or private sector or in both. The most direct and socially efficient way to protect old age from poverty due to health-care expenses is through social insurance. I do not think it would be impossible for private insurers to supplement Medicare with preventive, long-term care, and other benefits. But I do believe a private approach would only be practical if it picked up universality and other characteristics of social insurance. Since virtually everyone can expect to live at least into the 70s and has an older relative, mandatory coverage of the U.S. population through a contributory plan is an entirely reasonable proposition. Moreover, this would overcome adverse selection and assure sufficient contributions over the long haul. Contributions, starting long before the individual reaches old age, would be the basis for meeting expenses for the individual's future self years hence.

Various pathways to achieving this through a private/public partnership could be imagined. Legislation to require every

American to purchase private insurance for the extended structure of benefits. There would have to be national standards for minimum benefits offered and for administrative integrity and cost. Probably, to assure payout years hence, funds would have to be guaranteed by an equivalent of the Federal Deposit Insurance Corporation, which guarantees bank accounts of private depositors up to a maximum.

One might continue this sketch, but suffice it to say that the attempt to avoid a social insurance approach would still entail considerable governmental intervention. It would undoubtedly involve higher costs of administration than possible through a universal, mandated program (like Social Security). One might also envision a "social utility" approach, with services provided by a highly regulated private organization that is insulated from competition to achieve stability and serve unprofitable but desirable social purposes.

That is why I lview the basic response jto the demographic imperative to be the restructuring of Medicare.

D. The New Face of Medicare

Ultimately, the new Medicare should have this configuration:

a. Current benefit structure, covering acute inpatient care

b. Long-term care, including medical, nursing, dental and social services

c. Health promotion, disease prevention, and casefinding services

Operationally, this means: (1) geriatric assessment (and reassessment at regular intervals); (2) development of plans of care to promote capacity to function, based on the recent assessment; (3) emphasis on care at home and in the community; (4) assistance to families for support of the patient at home, such as counselling, respite service, chore service, and home attendants.

To maintain quality and to control costs, providers of comprehensive geriatric services must meet eligibility standards (e.g., training in geriatrics) and must be at financial risk (e.g., furnishing services at a fixed prospective payment, sharing in loss or surplus).

The foregoing elements-- comprising a complete range of short- and long-term care with cost and quality contorols -- can be realized in various types of organized care. One of the more promising is the social and health maintenance organization S/HMO). Four S/HMOs are being tested in the United States under different auspices (such as a nursing home, a health maintenance organization, a continuing care community). Through waivers of certain Medicare and Medicaid requirements, they receive an average per capita payment and may use it to support regular benefits of these programs and additional benefits. This makes it possible for Medicare beneficiaries to receive preventive services; these services are in the interest of the S/HMO to provide on the assumption that costs are avoided if acute care episodes are avoided. Custodial care for Medicare beneficiaries is provided for a limited period in a nursing home under a supplementary private policy.

Because of fragility of living standard as well as health, the very old population should be excused from any copayments. The criterion of eligibility to receive services should be need established through the assessment process and plan of care, and reconfirmed by periodic reassessment. This process should establish not only the needs of patient and family for service but also their commitment to provide care.

Because Medicare costs were not well controlled in the past, there is reason to believe that an expanded set of benefits as suggested above might be financed substantially out of prudent economies. A number of strategies are possible to balance Medicare's benefit structure by intra-program savings or by absorbing the funds as well as the functions of such other programs as Title 20 and Medicaid.

Nonetheless, if more funding is needed for additional benefits despite economies and if U.S. society is serious about the quality of late life, consideration would have to be given to tax policy. I think the American public would be willing to weigh this possibility with others. In the abstract, Americans object to tax-and-spond approaches. They are not keen to have government intervention. But history shows they are willing to support taxes earmarked for purposes they value.

Americans today are paying a smaller proportion of gross national product in federal taxes than in recent past. For example, pre-Reagan federal taxes were about 19 or 20% of gross national product; in 1984, they dropped to 18.5%. Meanwhile, federal spending rose from 21 or 22% of GNP to 24%, largely to accommodate defense policy. The gap between revenue and expenditures produced a $200 billion annual deficit and deepened resistance to federal spending for existing domestic programs, let alone any expansion.

The needs for reforming Medicare are urgent. Where economies fall short of freeing enough fundfs for comprehensive geriatric services, the benefit expansions whould be financed by new, earmarked taxes. The tax base should be income from whatever source -- investments as well as earnings. The new tax approach should support research and training of the kind mentioned above. Other revenue sources might be (1) increased taxes on tobacco and alcohol and dedicating them to Medicare; this raises an ethical issue if the program becomes dependent on unhealthy behavior; (2) a Medicare "royalty" on the commercialization of interplanetary space through the use of Federal installations.

Other possibilities include taxing employer contributions for health and life insurance, and surcharges on corporation as well as individual income taxes. (6)

At the same time as new taxes are raised, the entire Medicare program must be run as prudently as possible. Since Medicare is embedded in the health care system, its economical operation depends on system-wide reforms. The United States is witnessing enormous changes in the financing and organization of care, notably in the commercialization of services, the proliferation of health maintenance organizations, the combining of providers of services of various types under one administration, and the combining of providers and insurers. The new conglomerates are organized often as venture capital enterprises. Employers are reshaping health insurance policies to require more cost sharing by beneficiaries. It remains to be seen whether these changes will improve the quantity and quality of coverage substantially or make way for profits without effecting major reductions in costs of the entire system.

Medicare has taken the lead in altering payment arrangements for hospitals. Medicare has shifted from cost-based reimbursement determined retrospectively to per case prices based on about 470 diagnosis-related groups.

This classification scheme has drawbacks from a geriatric point of view, since it is difficult to classify and receive adequate payment for the patient with multiple diagnoses and varying severity of illness. (The system pays somewhat more for people over age 69 or for one co-morbidity; these allowances, however, do not truly cover severity and complexity of many geriatric cases, especially the most frail.) The method provides incentives to avoid the more difficult cases covered by a DRG and to discharge patients as early as possible; however, the DRG system does not control for quality of care nor does it recognize that a patient who may no longer need hospital services still may not be be discharged safely to his or her home or cannot be discharged to a nursing home because no bed is available. The new Medicare payment system appears to assume the existence of long-term care services and circumstances that may, in fact, not exist.

The extension of DRGs to office practice has been proposed but seems unworkable. At the moment, Medicare reimbursement for physician services copies the private system by favoring procedures. While this benefits the cardiologist and the surgeon, for example, it underpays primary care physicians for time and effort in diagnosis and treatment. This is a barrier to geriatric practice.

No payment system by itself will assure proper consideration of the patient's needs. That must come from the professionalism of the practitioners and managers of the system and the wisdom of its financiers. Unfortunately, the bulk of American physicians and hospitals have taken advantage of the trust accorded them by Medicare and other third-party systems. Their incomes have risen sharply; services have been overutilized; resources have been extravagantly consumed. In reaction to this, American employers and the Medicare administration may have gone overboard in emphasizing economy at the sacrifice of access to services and their quality.

It may be too much to expect any formulas to produce automatically an equitable system of service. Negotiation among fair-minded parties may be a cliche, but may be the safest approach to resolving cost, access, and quality issues.

There remains the need for coordinating the new Medicare with programs providing social services and other supports necessary for the survival and quality of life of the Medicare patient. Coordination is required among Medicare, Medicaid, Older Americans' Act programs, Title 20 (social service) programs, Veterans Administration programs, and housing, transportation, and legal services. The reformed Medicare program should absorb some of these programs. In particular, it should lead to the elimination of Medicaid.

The establishment of a true health policy for an aging America needs the greatest wisdom the Nation can find. I have proposed establishing a National Commission on Long-Term Care composed of leading lay persons with no close connection to the health services field. The commission would conduct its own investigations and studies to produce a report and recommendations in a limited period of time. The panel's scope would cover benefits, financing, delivery organization, research, education, facilities, and health and social services. The commission would consider which functions would be best provided by the public sector and the private sector. Its views may expedite the adaptation of major institutions of our society to the needs of the growing elderly population.

D. Conclusion

This paper has argued for the restructuring of Medicare as a necessary societal adaptation to the growth of a very old population. The approaches offered have these goals:

1. Completion of the protections against impoverishment in old age for reasons related to sickness

2. Promotion of service benefits, practitioner training and delivery systems suited to the geriatric needs of patients and families

3. Recognition that life in America is, on average, a long life for which we do not now allocate sufficient financial and service support.

4. Assurance to taxpaying adult children that their incomes will be protected against major expenses of parental health care.
5. Affirmation of the dignity and value of very old people, by providing a humane system of comprehensive geriatric care.

6. Efficiency and effectiveness in meeting the needs.

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FOOTNOTES

* Notable is the work of Professor Anne R. Somers. See her special article, Long-Term Care for the Elderly and Disabled. NEJM 307:221-226, 1982. She proposes eliminating Medicare's statutory bar against custodial care benefits, consolidation of certain Medicaid, Title 20 and other public funds, cost-sharing for long-term benefits, and a new federal, state, and community program to coordinate long-term care.

Footnote 1: In 1984, the actuarial value of Medicare was $2,210 a year, about one-third of the median income of elderly persons; the American Association of Retired Persons has estimated the cost of comparable private insurance to be $3,400 a year. Source: Aiken LH and Bays KD. The Medicare Debate: Round 1. NEJM 311:1196-1200, 1984.

Footnote 2: As with other public assistance, Medicaid programs set a limit on income and assets the individual or family may hold and be eligible for coverage. An owned home is excluded in the counting of assets.) About 3.5 million elders are in Medicaid as well as Medicare.

Footnote 3: In 1985, older Americans are spending an even higher proportion of their income on health care than they did before enactment of Medicare (15%). Despite the improvement in Social Security cash benefits for retirees, incomes of the elderly are more likely to hover about the poverty line than are the younger-adult incomes. Nonetheless, the program's hospitalization deductible has doubled to $400 in the last four years; and there is continued exposure to inflationary expenses in the nursing home. An estimated one-third of Medicare patients who enter nursing homes for long-term care are officially poor within six months. In New York State, annual nursing-home expense can reach $40,000.

Footnote 4. Medicare costs have risen rapidly, about 15 percent a year. The inflation not only eroded the financial protection goals embodied in the original set of benefits but also blocked any addition of benefits for long-term care, outpatient drug and preventive care. Between 1976 and 1981, Medicare beneficiaries experienced an 80% increase in out-of-pocket liabilities for noncovered services and products. In their search for security, elderly persons bought private "Medigap" insurance, which, while covering the Medicare deductibles and coinsurances, did not cover long-term care, outpatient drugs, or preventive care.

Footnote 5. Between 1960 and 1984, average life expectancy for men at age 65 has risen to 14.6 years from 13 and for women to 19 from 15.8. The increases are 1.6 years for men and 3.2 for women. The author is aware that improved life expectancy after age 65 reflects lower mortality rates for cardiovascular disease, presumably due in part to efforts against hypertensive disease and atherosclerosis.)

Footnote 6: Former Social Wecurity Commissioner Robert Ball provides a reasonable strategy of cost containment and increased

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revenues. He takes note of the llarge deficit in the federal budget and the subsidies given to Part B (supplementary medical insurance, largely physician coverage) from federal general revenues. He wisely points out that Medicare cannot effectively control its costs independently of the rest of the health care sector of the U.S. economy. An all-payers system,m in which a state government regulates the payments that any third-party payer can make to institutions, has been effective in New York State; it held inflation in hospital prices below the national average for several years. Such a system is embodied in a proposed bill in Congress (Kennedy-Gephardt); under it, state programs that meet federal standards would receive federal aid, very much in the style of the Canadian national health insurance. (Incidentally, this model would have been proposed as part of the 1935 Social Security Act had not President Roosevelt feared the political influence of the American Medical Association in defeating the entire measure.)

For new revenues, Mr. Ball's suggestions include (1) raising taxes on cigarets and alcohol, dedicating the increased income to Meldicare; (2) extending Social Security coverage to certain state employees (now exempted) and shift their contributions to Medicare; (3) expanding the Social Security tax base by counting employer contributions to group health and life insurance and diverting this income to Medicare. By such measures, enough money would be raised to eliminate the Part B subsidies and permit expansion. (Ball RM. Medicare: A Strategy for Protecting and Improving It. Generations, Summer 1985.)

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STATEMENT OF ELLEN WOODALL

My name is Ellen Woodall. I am 43 years old. The last two years of my life have been an all-out battle with catastrophic illness, and with government and hospital policies which at times seemed structured to bring about my death.

In September of 1983, I had just returned from a trip to Mexico. I had what appeared to be a case of "Montezuma's revenge," and I gave it little thought, until it grew more severe and wouldn't go away. Feeling increasingly weak and still experiencing the symptoms, I went to have some blood tests. I was diagnosed with primary biliary cirrhosis, a rare liver ailment. It's one form of cirrhosis that's not related to drinking. The doctor gave me medication to stop the diarrhea and told me that I had 20 years to live if I watched my diet.

After that diagnosis, I began to feel drained of all strength, which is unusual for me. I guess the clincher was when my son, who's s student at a special high school for students interested in medicine, was looking through a textbook at people in stages of primary biliary cirrhosis. It was horrible. I remember thinking I'd take my own life before I'd get in that condition. Sadly, I was to learn I'd get dangerously close.

I began to feel weaker and weaker, and my skin took on a yellowish cast. By the time I knew I was really sick, I had 2 weeks of insurance coverage left and had lost my job as a result of my illness.

I knew that I was going to need continuing medical care, so I spoke to my insurance agent. He said he could get me better policy with a different company. I agreed–naturally I wanted the most comprehensive coverage I could get. My agent, unfortunately, in the application denied to the company I'd ever had cirrhosis. He applied for a $500,000 policy. So I wouldn't know he'd lied about my medical history, he rushed me into signing before I had adequate time to read the policy. After the policy had been purchased, I learned that any claims related to serious liver ailments would not be honored. In effect, I had no insurance. After receiving this unbelievable blow, I was informed by the people at a foremost organ transplant center that I'd probably need $200,000 for a transplant and related expenses. What could I do? I asked for additional testing–this time I wanted the straight story. Soon I was informed that I wouldn't live 20 years with my liver in this condition. What I had was an incurable disease–unstoppable, terminal. I had only a year and a half to live. My previous physician hadn't told me all these shattering truths because he "didn't want to hurt me." After conferring with doctors across the United States and other knowledgeable people, I knew that a transplant was my only option if I wanted to continue living.

I've always been able to manage my funds pretty well. I've worked hard and have always been able to set something aside in a nest egg for emergencies. I had some savings in the bank, although nothing too extravagant. I knew I could use it for a short time. When my illness prevented my continuing with work, I received unemployment compensation. I was desperately groping for any form of support. I called the Texas Department of Human Resources. They were of no help.

Within a matter of months, I had spent all of my kid's college savings on my medical treatments. I toyed with the idea of going on Medicaid–I probably would've been there soon anyway, so depleted were our resources. However, Medicaid doesn't pick up anything relating to transplants for persons over the age of 18. It soon became obvious that my illness wasn't the thing that would kill me–lack of funds would.

I made a lot of calls at this point, desperately trying to find financial aid. A Texas State official advised I move to a state which could provide greater benefits. New York, where AFDC (Aid to Families with Dependent Children) would probably pick up the cost of my transplant operation. This option seemed unworkable. After all, I had my roots in Texas and also, being terminally ill, I wasn't in any shape to pack and move that long distance. Another dead end.

As you can imagine, I was almost broke and very discouraged. My friends told me they'd raise the money for me, and I was grateful for that. Clearly, the government support systems was not structured to help someone like me. The private sector was probably the answer.

Realizing the seriousness of the situation, my son called one of the Houston newspapers, to encourage them to write my story and push for some donations from their readership. They weren't interested, although some small local weekly publications took up my cause.

By this time, my liver dysfunction had made me neon yellow and extremely weak. Nonetheless, my family and I embarked on an all-out fundraising effort. To reflect my condition, my sons and friends sold bright yellow balloons bearing the slogan

"Please help me live." In 2 weeks they made $3,000 on balloons alone. At least there was some interest and compassion out there.

I then took a trip to Washington, DC, to talk to legislators and see what other options might be available to me (a major corporation paid my way). It was during that visit that I met Chairman Pepper, who seemed to be the Congressman most interested in helping me. While I sat beside him in his office, he called Congressman Waxman, then OMB director David Stockman, and even the White House. Not even those knowledgeable persons could find a way of getting government support for me. But Mr. Pepper said he'd continue trying.

Additional attempts at fundraising followed, including a mass mailing to newspapers around the country. Contributions soon started rolling in. I thought to myself--this is exactly what President Reagan wants. The private sector doing what, in my estimation, the public sector ought to be doing. It was certainly a learning experience.

I went to three businessmen--people I'd never met before--who contributed $10,000 each. One Houston businessman donated $8,000 in stock. A Mexican-American group sponsored a chili cook-off which netted $400. I could go on and on.

I'd done some more reading on liver transplants and spoken with some medical experts. I knew that one of the most experienced facilities was the Deaconess Hospital in Boston. I called there and was quoted $150,000 as the price for a liver transplant and surrounding expenses. Dr. Jenkins would perform the operation if I could raise the money.

Because that price seemed so steep, I decided to do some more checking. I heard that only $80,000 would be required if they did the surgery in Memphis. At that time, in March of 1985, I had $77,000. Memphis was one of the three prime transplant centers in the country (also Pittsburgh and Minnesota). Then, I was told that I needed $80,000 just to be placed on the waiting list for a liver transplant in Memphis--I had to have all the cash upfront before they'd even consider me. I would need $3,000 more. A businessman in Houston came to my rescue--he gave me $10,000. I was finally over the hump. Still, it took another month to make arrangements. I knew we couldn't delay much longer.

After raising this huge sum on my own, I was to the point where I wanted an established team of nurses and doctors. I wanted the best. Deaconess in Boston still seemed to fit this description. Little by little, more donations had come in. Congressman Pepper made an impassioned plea to a Houston TV station and they began a campaign to help me. It wasn't long until I had the $120,000 which Deaconess needed, in July 1985. (By this time, the itching was so bad, I scratched my feet with hairbrushes until they bled.) Mead Johnson supplied me with free medication for the period of March 1985 to November 1985.

At this point, I want to tell you something. I was able to do all this, and I'm alive today, because I am a survivor. I am fortunate to have a background in advertising and public relations, so I know how to reach people and how to get my message across. The average person probably wouldn't know how to go about it.

I talked to Dr. Jenkins at the hospital in Boston. He couldn't believe that I had raised all the money. "You've run a marathon. Sit back and we'll take care of the rest." What comforting words.

The surgery needed to be done as soon as possible, before the heart, lungs and other organs began to deteriorate. I was ready, believe me.

My bilirubin count, registering the bile level in the bloodstream, by this time was dangerously high. I had a 24-hour itch and was sleeping about 18 hours a day. Something had to give.

Then, one week before I was scheduled to be put on the organ waiting list, I got a new estimate of charges--$180,000! They said I would have to pay in advance. I told them I was good for most of that sum but couldn't pay it all up front on such short notice.

Most of the drama continued. One November 25, 1985, Dr. Jenkins called and said I should come up for surgery. He performed the operation and I was an exceptional case. I never needed the intense care unit. The surgery lasted 10 hours (18 hours is the norm). I stayed in the hospital 5 weeks and 2 days, although I know that 8 weeks is the average. Even with the severe rejection I experienced, I snapped out pretty well. The bill for the hospital came to $78,500. Dr. Jenkins' fee alone, came to $10,000. On top of that, I had to pay for numerous other doctors, anesthesia, ambulance, out patient expenses, etc.

I am back home--have been for almost three weeks. I'm in the care of University of Texas doctors who report their finding to Dr. Jenkins weekly. I'm back on a regular sleep schedule now--10 hours a day--and my mind is clear once more. I will return to Boston for periodic biopsies and check ups.

I still have medical bills aplenty and, the Texas Department of Human Resources finally eligible for Medicaid, the medical program for the needy, but not all of my determined. I am on going bills are covered.

Things would've been different if I'd had a legitimate insurance policy. Many of my medical bills would've been covered.

However, the transplant would not have been covered. Liver transplant is the most serious, dangerous and demanding type of surgery. It is seen as quite extreme. Most insurance companies won't touch it.

If I hadn't gotten the transplant, I would've become indigent, and been placed in a charity hospital. The cost of maintaining me there through the final stages would've been a hell of a lot more expensive than the transplant, and would have kept me in a barely human state, living in agony until death most probably within a year or two.

I was able to battle back, but I'm sure many others cannot.

I think you can tell from this statement that I do not want to become a ward of the state. I don't expect government to do everything for me. But, when a person has a catastrophic illness like this, I do think there should be some support mechanism. My transplant was expensive, but it was a far less costly alternative than a long-term hospital. And there is no doubt I would have died.

I still have serious expenses to face. There is the $800-1,000 a month for medication and blood tests that I'll have to pay the rest of my life. And, after what I've been through, that could be many years. I don't plan on dying for a long time. Insurance must cover the post operative expenses also.

Congressman Pepper, I sensed your compassion before, when you tried to help me. I applaud you now for exploring alternatives so that the catastrophic needs of all Americans might be addressed. Thank you.

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